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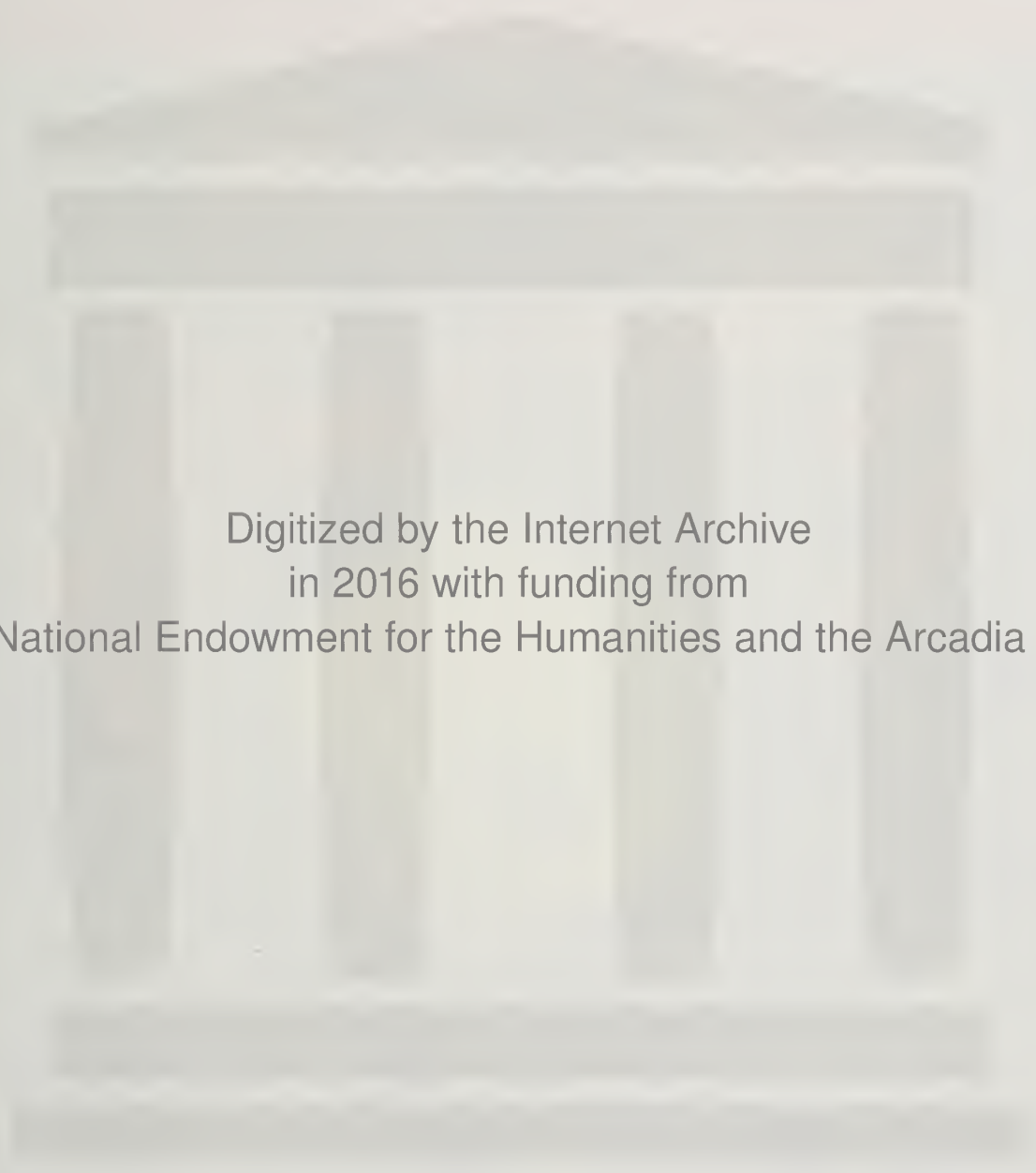


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FORECASTING THE FUTURE

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In moderate depression and anxiety

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Limbitrol[®] DS

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Please see summary of product information on adjacent page.

See the improvement in the first week¹

- Sleep improvement in 74% of patients after first h.s. dose²
- Significantly faster relief—62% of total four-week improvement evident in first week versus 44% with amitriptyline alone¹
- Dramatic first-week reduction in somatic complaints²

% Reduction in Somatic Symptoms²

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Reduced 90%	Reduced 86%	Reduced 72%	Reduced 62%	Reduced 60%

- Only 1/3 the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar¹

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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In moderate depression
and anxiety

Limbitrol[®]

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Limbitrol DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (N)

References: 1. Feighner JP, et al. *Psychopharmacology* 61: 217-225, Mar 22, 1979. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ

Limbitrol[®] (N) Tranquillizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during ocular recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring

reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. **Limbitrol DS** (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. **Limbitrol** Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: Double strength (DS) Tablets: white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets: blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500, Tel-E-Dose[®] packages of 100, Prescription Paks of 50.

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FROM THE EDITOR

Predictions

Predictions are always popular ways to begin a new year . . . but we wanted to bring you predictions that would carry some significance, or, at the very least, have the possibility of coming true. So, we figured, why not make some predictions about the legislative arena? After all, what could be more significant to the medical profession than how legislation promises to shape up in the year ahead? And as far as accuracy is concerned — well, we figured we stood as good a chance as anybody at second-guessing the legislature.

Therefore, in this issue, you will find a report prepared by OSMA's Department of Legislation, in which predictions on what issues will be hot — and what will not — will hopefully provide you with a glimpse of what lies ahead. As a bonus, throughout the staff-written story, you'll find predictions made by some of OSMA's past presidents. Who will be right? Keep watching *OHIO Medicine* throughout the year. We'll let you know.

Also in this issue, look for a story on the new cholesterol levels and what they mean. Cholesterol has suddenly become a very popular topic, both with the public and the media — and you may find more than one of *your* patients strolling into your office for a test, and an interpretation of the results. This article, written by Associate Editor Deborah Athy, may offer just the guidelines you need. Don't miss it!

It's hard to know what to do, anymore, when we learn of a seminar or conference that is focusing on the subject of AIDS.

Should we cover it, in hopes that there will be some new information that we can pass on? Or will it be just another rehash — more media hype for a problem that offers no cure . . . and little hope for one? Fortunately, the recent conference on AIDS, sponsored by the Commission on Interprofessional Education and Practice and co-sponsored by the OSMA offered a new dimension on the subject. No new information, here — not really. But no rehash, either. We hope you'll take a look at "Snapshots. An Ethical Look at AIDS," if nothing else, just to acquaint yourself — or reacquaint yourself — with the types of ongoing dilemmas that need to be addressed by all professionals.

Finally, I'll just briefly call your attention to this month's "Out of Practice" column, written by Editorial Assistant Michelle Carlson. If you ever thought that the TV coroner Quincy was bigger than life — well, obviously you've never met Stark County coroner Dr. James R. Pritchard!

Next month, *OHIO Medicine* will take a look at the re-awakening interest in cancer.

We hope 1988 promises to be a good year for you — and the profession. One without surprises. For our part, we promise to keep you in touch with what lies ahead for medicine . . . and if *you* have any ideas or suggestions, won't you let us know?

Karen S. Edwards

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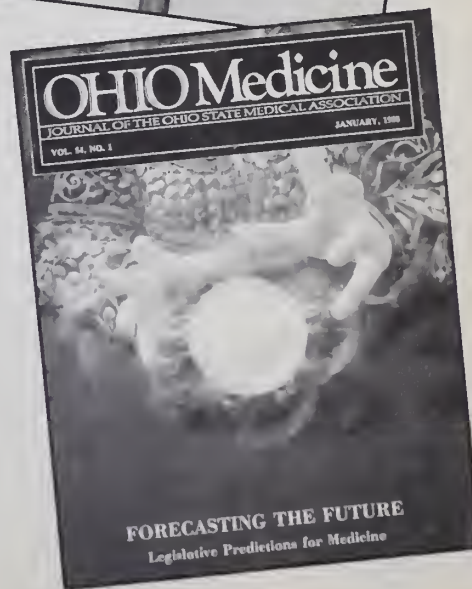
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OUR COVER

This month's cover was photographed by freelance artist and photographer Larry Hamill. We wish to thank "Pearls of Wisdom," 3244 N. High Street, Columbus, Ohio 43202, and its owner Esther Matthews for the loan of the crystal ball shown in the photo.



A group of five healthcare professionals are gathered around a table, intently reading 'Postgraduate Medicine' journals. In the background, a surgeon in green scrubs and a blue cap looks on. To his left, an older man in a suit and glasses reads a journal. In the center, a woman in a white lab coat is captured mid-bite of a green apple while holding a journal. To her right, a woman in a blue button-down shirt also reads a journal. In the foreground right, a man in a plaid shirt is focused on his journal. A large, detailed image of a 'Postgraduate Medicine' journal cover is positioned in the bottom left corner, showing the title and a list of featured articles.

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Resolves for '88

By D. Ross Irons, MD

brochures the OSMA has developed to educate your patients on vital socioeconomic and health education topics. The very popular Medicare brochure we printed last year will be updated in the near future to include the latest developments. In addition, we will be printing other brochures on socioeconomic topics that you may share with your patients. These brochures are important because they let patients know *your* side of the story.

In addition, we will step up our efforts to reach all Ohio citizens through the news media. We responded swiftly when the blame for the proposed Medicare premium hike was laid at the feet of physicians. More recently, we prepared spokespersons around the state to respond to HCFA's release of hospital mortality data. I firmly believe these efforts are vital if we want to get the facts before the public.

Furthermore, we are evaluating the feasibility of developing a patient advocacy and insurer performance review network, as initiated by the Indiana State Medical Association and proposed for Ohio by William Marshall, MD, Second District Councilor. This program would establish a mechanism to address third-party carrier problems experienced both by patients and physicians.

All of these activities are important because, if we don't fight to keep outside interests from controlling health care, who will? However, the leadership of the OSMA knows that in order to remain viable in the future, it is equally vital for us to continue to offer those services that will keep our membership intact. Surveys, both locally and nationally, reveal that members are becoming more

interested in specific services offered by an association, rather than general policies and philosophies. To that end, the OSMA will continue to develop programs to more ably offer these types of services.

The OSMA Ombudsman is well-known to most members. This service intervenes on behalf of physicians who are experiencing problems — reimbursement and otherwise — with third-party carriers. The OSMA's contract analysis service, which was launched in the spring, has helped many physicians who need assistance with evaluating contracts.

For the future, the OSMA is evaluating the feasibility of a "Legal Hotline" to offer on-the-spot legal advice to OSMA members. And, as always, we will continue to evaluate and review such standard member services as car leasing, credit cards, insurance programs, etc.

The above-mentioned items are just a few of the activities we are undertaking to help us achieve our goals for 1988. Keep in mind, however, that even as we set these resolutions on paper, we know that 1988 will bring even tougher problems to address. The challenge of leadership is balancing the new demands against the need to complete those plans and programs already in progress.

We have several items of unfinished business from 1987. First, there is the OPEN program. Ohio Project Elderly Needy was developed by the OSMA to help identify and assist those elderly whose financial status kept them from seeking medical care. This program is important not only because of the help it offers the elderly needy but also because it

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Traditionally, at the first of each new year, we set aside time to reflect on those goals we would like to achieve during the coming twelve months. As important as this is on a personal level, it also is important for an organization. I would like to share with you several of the OSMA's "resolves" for 1988.

First and foremost, we resolve to continue our fight to keep outside interests from destroying the physician-patient relationship. In the ongoing maelstrom of the changing health-care environment, third-party intervention has — and will continue to be — a special problem. To that end, I propose a "strike force" centered at OSMA headquarters to serve, not only the state's physicians, but also our patients.

This strike force will address the problem on several fronts. Legislatively, we will continue to monitor all developments at the Statehouse and step in when our rights and the rights of our patients are threatened. Furthermore, we will increase our efforts to strengthen the physician-patient relationship by helping you educate your patients regarding this changing medical environment.

By now most of you are familiar with the series of

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of Tagamet.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, Tagamet has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 5 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving Tagamet.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of Tagamet HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to Tagamet therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

Tagamet has been reported to reduce the hepatic metabolism of warfarin type anticoagulants, phenytoin, propranolol, chloridazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when Tagamet is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either Tagamet 300 mg q.i.d. or 800 mg b.i.d. concomitantly with a 300 mg b.i.d. dosage of theophylline (Theo-Dur®; Key Pharmaceuticals, Inc.)

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg b.i.d. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. [Note: All patients receiving theophylline should be monitored appropriately regardless of concomitant drug therapy.]

Lack of experience to date precludes recommending Tagamet for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks. Generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash, reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving Tagamet, particularly in high doses for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in Tagamet treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed, cholestatic hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely.

A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving Tagamet has been reported.

How Supplied: Tablets: 200 mg tablets in bottles of 100; 300 mg tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only); and 800 mg Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg/5 ml in 8 fl. oz. (237 ml) amber glass bottles and in single-dose units (300 mg/5 ml) in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg/2 ml in single-dose vials in packages of 10 and 30, and in 8 ml multiple-dose vials in packages of 10 and 25.

Pre-filled Syringes: 300 mg/2 ml in single-dose pre-filled disposable syringes.

Plastic Containers: 300 mg in 50 ml of 0.9% Sodium Chloride in single-dose plastic containers in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg/2 ml in single-dose ADD-Vantage® Vials in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

Tagamet HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

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RESULTS

AIDS, Sex and Dope: A Reevaluation of Ethics and Morals

By Howard C. Adelman, MD

Editor's Note: *This editorial is reprinted from the January, 1987 issue of the Trumbull County Medical Society Newsletter.*

Bubonic plague, syphilis, leprosy, influenza, smallpox: Infamous scavengers and killers throughout the history of humankind. In those superstitious bygone eras, these natural diseases with now-recognized specific etiologies, were attributed to the wrath of God: punishment for human transgressions. Today, these diseases are no longer a major threat. Specific antibiotic therapy, vaccination and supportive care have replaced the Great Fear. Thank God we have progressed beyond our ignorant and superstitious past — or have we?

Intellectually, we are all familiar with AIDS. Our medical journals, radio, television and newspapers make it almost impossible for us not to know about its nature and transmission. We all know who are in the high-risk groups and it comforts us to know that we can lay blame on the homosexuals, the drug addicts, and other presumed "low life" organisms in our society. Because of them and their immoral behavior, we have again brought the "Wrath of God" to

bear. Isn't that why the disease is now spreading to the heterosexual community?

Thank God we have progressed beyond our ignorant and superstitious past!

Knowledgeable educators, epidemiologists, sociologists and a lot of other "ologists" have proposed that sex education be taught in the schools along with education about the dangers of illicit drugs. Because of high teenage pregnancies and the

"Test positively for HIV and you not only join the ranks of the unemployed, you are shunned."

extensive drug problems now involving grammar school children, these educational programs have been advocated for children from kindergarten age on up. This has apparently created a conflict for those who most generally advocate the "Wrath of God" theory concerning those afflicted with AIDS, unwanted pregnancies and drug addiction. Can we really

expose our tiny, innocent tots to such "immoral" subjects as sex education and information about illicit drugs? Their answer is a resounding: "No!"

Thank God we have progressed beyond our ignorant and superstitious past!

The military establishment has instituted mass screening for the HIV virus. Never mind false positive results or considerations of the sensitivity, specificity and predictive values of the test: Let's get rid of the queers! Let's also do universal drug screening. As long as we're going to ignore those parameters, we might as well get rid of the junkies too!

Thank God we have progressed beyond our ignorant and superstitious past!

Unreasonable fear of AIDS has forced these measures. Test positively for HIV and you not only join the ranks of the unemployed, but you are shunned by the community and your best friends. You have now become our 20th century lepers. This projected attitude of judgmentalism naturally helps epidemiologists keep track of the disease because its victims are so willing to come forward.

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

The AMA Physician Opinion Poll — How does *your* opinion stack up?

Medicare, AIDS, adolescent health, drug testing and physician supply were a few of the topics on the AMA's 1987 Survey of Physicians and Public Opinion, which, each year, seeks to uncover physician attitudes on health care issues.

How do your own attitudes measure against the 1000 U.S. physicians represented by the survey? See for yourself:

• The Main Problem Facing Medicine . . .

The survey's only open-ended question gathered a larger variety of answers than past surveys have yielded. Cost was at the top of the list, followed by professional liability, government regulation, access/distribution, quality, third-party reimbursement, organization of medical care and loss of physician autonomy.

• Physician Supply . . .

Last year, physicians felt there were too many doctors — this year, hardly anyone felt that way. In fact, this year marks the first time since 1981 that figures in the "too many" category have dropped so low (39%). Only 6% felt there were *too* few physicians — while the majority of respondents (52%) voted for about right.

• Patient load . . .

Is your patient load increasing? decreasing? about the same? Most of the respondents (37%) felt their load was increasing. So, too, did young physicians (those under 45), women physicians, ob/gyn specialists, internists and pediatricians. General/family practitioners, however, noted a

declining patient load — as did 17% of the survey's respondents.

• HMO Practices . . .

The majority of physicians responding to this survey (58%) indicated they had no intention of practicing in an HMO in the future — largely because it meant loss of autonomy. Other reasons given were: HMOs provide poor quality care (10%); the respondent was satisfied with the status quo (8%); or because HMOs are considered too profit-oriented (5%). Younger physicians, however, were more willing to consider HMO practices — as were 37% of the survey's respondents. Why? Because 51% felt they would be forced into it; 12% thought it might ease administrative duties, and 11% see HMOs as a future trend.

• Peer Review . . .

Survey participants were asked to respond to two questions on this subject. The first asked, within the last 12 months, did you experience what you believed to be an inappropriate action by a peer review organization? Well over half (74%) responded they had *not* experienced inappropriate action. However, some specialties in particular did report inappropriate actions — namely internists, general/family practitioners and surgeons. On the question "does peer review place greater emphasis on cost containment, quality — or does it strike a balance?" — 35% responded that there was a balance between cost and quality; 32% felt the emphasis rested on cost containment; and a small minority (9%) felt the PROs' emphasis was on quality.



Smoking's new image

Cigarette smoking has often been associated with image. Picture, for example, a cigarette dangling from the mouth of Humphrey Bogart or Joan Collins extending a cigarette in a slim gold holder, and immediately you receive a certain feeling about the kind of person on the other end of the cigarette.

But according to the latest annual report issued by the American Lung Association, the image evoked by *today's* smoker is neither Bogart's brand of macho-tough, nor Collins's kind of drop-dead glamour. Instead, according to the report, today's average smoker is likely to be less educated, earn poorer grades in



school, and work in a less prestigious occupation than the average non-smoker . . . in other words, not exactly the kind of image to die for.

Experts guess that the new image has evolved as better-

educated people become better informed about the serious health hazards of smoking . . . and, certainly, it may be just the incentive some image-conscious people need to kick the habit for once and for all.

At-home monitoring

A recent issue of *Archives of Ophthalmology* describes a new device that glaucoma patients can use at home to better monitor their intraocular pressure.

Jacob T. Wilensky, MD, of the University of Illinois College of Medicine at Chicago, and colleagues say the "self-tonometer," developed by one of the researchers, is safe, easy-to-use and can provide information useful in managing a patient's condition.

The authors say 24 glaucoma patients and eight normal subjects were taught to use the self-tonometer, which is the size of a small briefcase, and obtained highly-accurate readings without interfering with their normal activities. The device is designed to help detect intraocular pressure elevations that might not be apparent in a single reading in a doctor's office.

Male physicians earn more than female counterparts

A recent study conducted by the AMA's Socioeconomic Monitoring System (SMS) reports that male and female physicians continue to differ in terms of net income, number of hours spent working and weekly patient visits.

The results, which are based on telephone surveys with 4,000 physicians, show that the average net income of all female physicians was \$73,100 compared to \$118,000 for male physicians. Male general and family practitioners made almost \$14,000 more than females in the same specialty category and at the same career stage, while male anesthesiologists with 10-19 years of experience made over \$70,000 more than female anesthesiologists with the same number of years experience.

The survey also showed male

physicians spend a greater number of hours in their practices each week than female physicians. Male physicians spent a mean of 58.2 hours per week in their practices, six more hours per week than the female mean of 52.2.

Finally, male physicians reported seeing more patients than female physicians. Male physicians had 120.3 patient visits per week while female physicians had only 98.2. The most extreme case is pediatrics, where male physicians saw 50.9 more patients per week than their female colleagues.

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COLLEAGUES

Frederick C. Robbins, MD, Cleveland, Nobel laureate and professor emeritus and dean emeritus of the School of Medicine at Case Western Reserve University, has won the prestigious Abraham Flexner Award for 1987 for distinguished service to medical education . . . **Lester A. Hamilton**, MD, Athens, and **Leland P. Randles**, MD, Athens, have received Certificates of Distinction from the OSMA recognizing 50 years of medical practice . . . **Martin Alpert**, MD, Cleveland, has been named to the American Lung Association's President's Council . . . **Devinder S. Mangat**, MD, a Cincinnati facial plastic surgeon, has been elected to a one-year term as Mid-Western Regional Vice President of the American Academy of Facial Plastic and Reconstructive Surgery . . . **R. Terrell Frey**, MD, Cincinnati, has been elected to a two-year term as secretary of the Ohio State Radiological Society . . . **Michael W. Devereaux**, MD, Shaker Heights, has been appointed to the Professional Advisor Board of the Alzheimer's Disease and Related Disorders Association of Cleveland . . . **Mary C. Moebius**, MD, Oxford, chief radiologist and director of imaging services at McCullough-Hyde Memorial Hospital, has been elected to serve as chief-of-staff for the coming year . . . **Craig Strafford**, MD, Gallipolis, has been elected to a three-year term as secretary-treasurer of the Ohio section of the American College of Obstetricians and Gynecologists . . . **Gerald Price**, MD, a Cincinnati family practitioner, has been named medical representative for the professional advisory committee of Clermont Home Health Care . . . **Beatrice Lampkin**, MD, Cincinnati, has been awarded a grant from the national chapter of Phi Beta Psi Sorority for cancer research . . . **Zaiful Girgis**, MD, a Springfield OB/GYN, has been named medical director of Planned Parenthood of West Central Ohio . . . **James Wasserman**, MD, Dayton, has been appointed associate professor of psychiatry and coordinator of outpatient services for the Department of Psychiatry at Wright State University School of Medicine . . . **James Jacques**, MD, Steubenville, director of radiology at Ohio Valley Hospital, has been selected to serve on the board of trustees of the American Cancer Society, Ohio Division . . . **Raymond S. Lupse**, MD, a retired Youngstown OB/GYN, has been elected president of the American Cancer Society, Ohio Division . . . **Richard D. Ruppert**, MD, Toledo, president of the Medical College of Ohio, has been elected secretary-treasurer of the American Society of Internal Medicine . . . **G. Terence Reuland**, MD, Cincinnati, has been re-elected president of the American Lung Association of Southwestern Ohio . . . **Mary Jo Welker**, MD, New Albany, has been elected vice speaker of the Ohio Academy of Family Physicians . . . **Daniel L. Storer**, MD, Cincinnati, has been installed as president of the Ohio Chapter of the American College of Emergency Physicians . . . **David F. Mitchell**, MD, Dayton, has been appointed medical coordinator of the Inpatient Rehabilitation Unit at Miami Valley Hospital . . . **John D. Bullock**, MD, Dayton, chair of ophthalmology and professor of plastic surgery at Wright State University School of Medicine, has been listed in the first edition of "Who's Who in Emerging Leaders in America."



Raymond S. Lupse, MD



Daniel L. Storer, MD

Second Opinion . . . continued

Thank God we have progressed beyond our ignorant and superstitious past!

Whatever happened to reason, tolerance and compassion? Are we still driven by the same fears our ancestors experienced? Are we so eager to place blame that we overlook prevention and control? Have we overlooked God's qualities of mercy and forgiveness in favor of His wrath and ill temper? Does He really regard our ideas of "immorality," nonconformity and "vice" as capital offenses? Does He truly hate the cachectic victim dying of an opportunistic infection or the wretched unkempt addict

struggling with his own painful convulsive tremors as he tries to insert the needle of relief into his scarred, thrombotic and often infected extremity? How about the alcoholic in the terminal state of jaundice, anasarca, liver failure and coma? Shall we also hate these outcasts of humanity?

Thank God we have progressed beyond our ignorant and superstitious past. OSMA

Howard C. Adelman, MD, is the Director of Pathology at St. Joseph Riverside Hospital in Warren.

Next month, OHIO Medicine will look at cancer in Ohio — how far medicine has come, how far we have to go . . .

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OHIO MEDI-SCENE

*Quality of care . . . AIDS — a New York view . . .
teenage pregnancy . . .*

Quality of care — its past, present and future

Ten years ago, the quality of health care in this country was never an issue.

"We knew there was quality in the system," says Dennis S. O'Leary, MD, President of the Joint Commission on Accreditation of Hospitals (JCAH). Dr. O'Leary was this year's speaker at the annual Fulton Memorial Lecture, commemorating Richard L. Fulton, MD, a past president of the Ohio State Medical Association.

Despite this measure of confidence, however, the JCAH has built itself around the issue of "quality," committing resources to monitoring and measuring it, first in hospitals — now in a broader range of institutions, including ambulatory and mental health facilities, hospices and, next year, home health-care programs and alternative delivery systems.

But monitoring quality has become a necessary evil, insists Dr. O'Leary. "Today, we have to make choices regarding care, and it's worrisome because there is always the possibility of making the wrong choice."

Of equal concern is the fact that medicine isn't the only entity, these days, making health-care decisions.

"There has been a shift of power between the purchasers and providers of health care," explains Dr. O'Leary. An excess of both hospital beds and physicians means leverage now lies with those who purchase the care, consequently, business and industry — the largest purchasers of health care in this country — are gradually beginning to change the system, he says.

In addition, the new alternative care systems are creating incentives to deliver *less* care, causing both the public and the legislature to look harder at the question of quality.

"Physicians are more publicly accountable now than ever before," he says, a condition he believes will continue to be a way of life for the medical profession in the foreseeable future.

As a result, however, this public accountability has forced malpractice to resurface with a vengeance, causing doctors to look to tort reform for relief.

"Tort reform is a state-based issue," says Dr. O'Leary, "so we will probably see fifty solutions to the problem — and probably none of them very good."

And while state legislatures are

receptive to the idea of tort reform ("because the liability issue is across the board, affecting every profession") they are quick to accuse physicians of doing a bad job and telling them "we'll help you do your job better," Dr. O'Leary asserts.

Such help is often misguided, however, and, in some cases, almost laughable, he says, citing the case in the Florida legislature, where a risk management program was set up, and the facility told to have the program overseen by certified risk managers.

"Not only are there no certified risk managers in this country, there are no programs in place that could certify risk managers," Dr. O'Leary points out with a laugh.

Competition is yet another factor forcing doctors to prove to the public that they are delivering high-quality care, says Dr. O'Leary. "But quality of care is really a self-interest issue with us," he continues. "We are the ones who want to deliver quality care, so if you're asking the question, 'who is the one holding an ax over my head?', the answer is you are. Self-interest is what makes Johnny run. We have an instinctive desire to find quality care. It's healthy for

OHIO MEDI-SCENE

Quality of care . . . *continued*

us, and for our patients.”

But determining what constitutes quality care is a whole new ballgame, says Dr. O’Leary, who likens such care to a multifaceted, moving target. “Some of its dimensions are measurable, some never will be,” he comments.

Two dimensions which *do* lend themselves to measurability, he continues, are appropriateness of care and patient satisfaction. “And we should become more sophisticated than anyone else in measuring those dimensions,” Dr. O’Leary says.

What this means, continues Dr. O’Leary, is that physicians and the Joint Commission must learn to communicate with each other.

“Communication with physicians has been a problem for the JCAH for some time,” admits Dr. O’Leary, who says the organization’s often complex, obtuse and convoluted language is partly to blame. But if physicians don’t participate in this program, you can bet somebody a lot less friendly will, he says.

“The kitchen has gotten hotter for Congress. Special interest

Commission has decided to build a “better mousetrap” by developing the aforementioned “Agenda of Change” — a program which Dr. O’Leary predicts will meet the quality issue head on. This agenda will be built carefully, and with the advice of experts from all specialties. The proposed agenda will determine proper:

- clinical indicators
- organizational and management levels of care
- risk-adjustment levels
- ongoing interaction capability, as well as a new survey/accreditation procedure.

“We are six months into this project,” says Dr. O’Leary. “We decided if there was any doubt that we could accomplish this agenda, we would forget it. But we are finding that it is very feasible to do.” Will anyone be able to *use* it, though?

Dr. O’Leary says yes — as long as the software system eventually decided upon is very simple and very basic.

“If we have learned no other message, we hope we have learned the risk of data overload,” says Dr. O’Leary. He points out that, if the typical doctor is like him, “and you have to bend over to pick up a heavy print-out, you’re already angry before you start.”

Therefore, the JCAH is trying to size down its “developmental appetite.”

“We are hoping to end up with six to eight indicators,” says Dr. O’Leary, but he admits it will be a good 10 years before the menu is

“Two dimensions which lend themselves to measurability are appropriateness of care and patient satisfaction.”

Presently, the JCAH is attempting to come up with standards or guidelines, an “Agenda of Change,” that will place the medical profession on the cutting edge of such capabilities.

Admittedly, there will be some obstacles in the way, says Dr. O’Leary.

“There will obviously be problems and unanswered questions. However, we can determine the capability (of a facility) to deliver care, and we can ask whether or not that facility did deliver the care they are capable of giving. We should also ask about the treatment outcome — what happened to the patient?”

groups, like the 25-million member AARP (American Association of Retired Persons) are demanding more public accountability — and Congress is looking for relief from these demands. Lately, that relief has been spelled P-R-O.”

Originally, the PRO was set up to control cost — not quality, Dr. O’Leary explains. “But a funny thing happened on the way to Congress.” It was Congress, he says, who suddenly asked PRO to handle quality review — “but they didn’t set up any standards first. As a result, we have ended up with a loose review system with very high stakes.”

To confront this issue of quality, then, the Joint

completely fleshed out.

"It will happen," he emphasizes. "We will have a menu of clinical indicators across all of clinical medicine."

With these clinical indicators in place, then, any "funny numbers" that surface in health-care facilities will be analyzed to discover what the problem is and what can be done to make it go away.

"If we focus on hospitals in this manner, we may find out about the problems which are occurring in hospitals before the media does," he says.

The Agenda of Change will include two other points worth mentioning. First, it will attempt

to get some of the protections out of the system.

"The manual we use is full of protections," he says. "In fact, it protects everyone inside the hospital system — except the patient. Our priorities are all messed up." After all, he continues, "We're all grown-ups and we should be aware of what our responsibilities are."

Second, the agenda may include a separate chapter on the governing body of hospitals, and how that body should interact with the hospital's medical staff.

These changes, as well as a brand-new survey process, should be ready for implementation by

1992, Dr. O'Leary estimates. In conclusion, he sums up the JCAH's Agenda for Change this way:

"The Agenda for Change will put the Joint Commission in a far more supportive and facilitative mode in helping health-care organizations meet the responsibility for quality of care that the public, not the Joint Commission, has imposed on them. We're really talking about people making better decisions based on better information. That's where we need to be, and that's the course the Joint Commission has embarked upon."

— Karen S. Edwards

AIDS — a New York view

During London's Great Plague in 1665, many of the city's physicians, apothecaries and surgeons left the city, according to historical accounts. The plague eventually claimed an estimated 68,000 individuals.

Taking flight in times of pestilence isn't without a prototype. Physicians and others fled from Europe in 1347 to escape the bubonic plague. Later, yellow fever triggered an exodus from Philadelphia in 1793, according to the *Journal of the American Medical Association (JAMA)*.

The threat of AIDS has not sent physicians and other medical personnel fleeing in droves from major U.S. cities, but history may be repeating itself in more subtle ways.

Item: An AIDS patient in Maine unable to secure the services of a psychiatrist.

Item: The inability to organize a group of nurses willing to work exclusively at an AIDS-designated ward at Mt. Sinai Hospital in New York.

Item: Only one funeral home in Manhattan willing to conduct funerals for AIDS patients.

Although it is true that uncertainty clouds the method of transmission in 3-4% of AIDS-infected individuals, "We have to be guided by what we know," advises James Strain, MD, a Mt. Sinai psychiatrist and speaker at the 1987 Ohio Psychiatric Association Meeting. There is no evidence that AIDS is spread by any other methods except direct sexual and perinatal contact, sharing IV needles, and exposure to blood.

Thus AIDS is far-removed from the plagues of the past, the *JAMA* article points out. "AIDS has little in common with these (smallpox, bubonic plague, yellow fever) . . . The risks physicians took (in the past) were poorly understood and often quite large. The risks AIDS poses to most physicians have . . . been exhaustively evaluated; infection control measures make the risks manageable, if not negligible."

"Our job (as physicians and psychiatrists) is to stamp out irrationality," Dr. Strain agrees.

But even if irrationality is pared away from the big picture, the AIDS reality in itself is mind-boggling. Dr. Strain throws off a few facts for contemplation: an



OHIO MEDI-SCENE

AIDS — a New York view . . . *continued*

estimated 90% of hemophiliacs are HIV positive; 60% of drug users and 70% of gay males in New York City are HIV positive.

The agenda for the AIDS patient includes such realities as loss of finances, public assistance, career, housing and insurance; physical and social isolation; prejudice; uncertainty; and the difficult task of living with the stigma of the disease and lifestyle.

Thus the disease takes a toll not just on the body, but on the mind as well, Dr. Strain continues.

According to a recent survey, the most common symptom reported by AIDS patients is *fear*. Others include disillusionment, anxiety, anger, insomnia, demoralization, depressed mood, anergia and irritability, he says.

For some individuals who are uncertain whether they are HIV positive, *AIDS anxiety* permeates their lives, prompting such behavior as repeated doctor visits; repeated testing; obsessional thinking; a fixed belief of an AIDS diagnosis; and recurrent fears of dying.

One man, although he had never been tested, became so convinced he had AIDS that he seriously contemplated suicide, relates Dr. Strain. What the man thought were symptoms of AIDS turned out to be a urinary infection, he says.

Many AIDS patients also wrestle with varying feelings of stress and distress, he continues. "It's difficult to diagnose depression in the medically ill. We have to go back to the drawing board for

diagnosing depression and anxiety, especially when the signs are secondary to the physical illness."

When notified of an AIDS diagnosis, patients frequently experience a series of adaptive reactions similar to the four stages of grief, including an initial stage of uncertainty, the transitional period, a period of acceptance, and, finally, the preparatory stage.

When treating AIDS patients for depression, delirium, anxiety or other conditions, keep in mind that HIV patients respond more quickly and to lower doses than do other patients, says Dr. Strain. Medication can also cause side effects that mimic depression. Dr. Strain says to avoid barbituates, antihistamines and beta blockers.

AIDS is beginning to break new ground ethically and legally, inviting attention to issues such as confidentiality, informed consent, benefit disability and power of attorney, he continues.

He cites two current cases in New York City in which two men with AIDS have refused to tell their wives of their diagnosis. This places the physician in a very precarious position, he points out.

"We have never been closer to the rights of the individual with AIDS balanced against the rights of those who don't have AIDS," he adds.

While these legal and ethical ramifications are debated and hammered out in meetings, task forces and courtrooms across the nation, the medical profession has an obligation to provide full-scale care — including appropriate medical treatment, as well as psychotherapy, psychopharmacology and support groups.

"We have an enormous amount to offer," he concludes. "This is an unusual opportunity and need for psychiatrists to have a voice."

— *Deborah Athy*

Teenage pregnancy . . . the problem continues

Teenage pregnancy seems to be one of those problems which, despite the attention given to it here and in other publications (including the popular press) never seems to go away. If anything, the problem just keeps growing larger and larger.

Consider, for example, that the United States leads all developed countries in the rate of pregnancy among 15 to 19-year-olds, with an

estimated *one million* teenage pregnancies each year, resulting in about 500,000 live births. Four out of five of these pregnant mothers are unmarried and 30,000 are *under* the age of 15.

Here in Ohio, the statistics are just as startling. In 1985, for example, approximately 13 percent of all of the babies born in the state were born to teenagers.

Ignoring, for just a moment, the

immense *health* problem created by teenage pregnancy — consider the costs assumed by society.

"The public cost of teenage child-bearing runs approximately \$16.5 billion or about \$18,000 a year per child for each of its first 18 years of life," says Judith de Levie, MD, Clinical Assistant Professor, Department of Ambulatory Care at the Ohio State University Pediatric Clinic. Dr. de Levie recently addressed the topic of "Teen Mothers" at a conference on adolescent health, presented by the Ohio Department of Health, and sponsored, in part, by the Ohio State Medical Association.

Costs are often incurred, she says, because premature births, or low-birth weights can require these infants to spend days — sometimes months — in intensive care.

Yet, sometimes, even intensive care doesn't help the baby whose mother may not have received adequate — or, for that matter — *any* prenatal care prior to the delivery.

"For mothers who are 15 years or younger, perinatal outcome is generally poor," says Dr. de Levie.

Of course, health and costs are not the only aspects of "teenage mothers" coming under scrutiny. Studies in this area are both plentiful and ongoing, says Dr. de Levie.

One recent study, for example, examined the "type" of teenager who is likely to become pregnant at an early age.

"No unique psychological profile could be determined," says Dr. de Levie — but certain common characteristics were noted.

"Often, these girls were below average in school and had low vocational and educational aspirations," she notes. To prove the point, she cites another study, one conducted in 1983, where, of 1,300 adolescent girls under the age of 18, at least one-quarter had left school prior to their pregnancy.

Other studies have shown that teenage mothers are far from ideal

parents. They generally spend less time with their infants; are less accepting of them; less sensitive to their needs; and carry on more negative communication with them than those mothers who are older.

"We don't know, yet, the long-term consequences of teenage pregnancy," admits Dr. de Levie — but there is the risk that children, born of teenaged mothers, will have lower intellectual ability and be at increased risk of behavior problems — and even early death, since accidents and violence are not uncommon in these households.

Perhaps the most puzzling part of the problem, however, is the fact that not only are an increasing number of teenage girls becoming pregnant — but that they are becoming pregnant over and over again.

"Approximately 60 percent of those girls who are pregnant by the time they are 16 are pregnant again before they are 19," says Dr. de Levie.

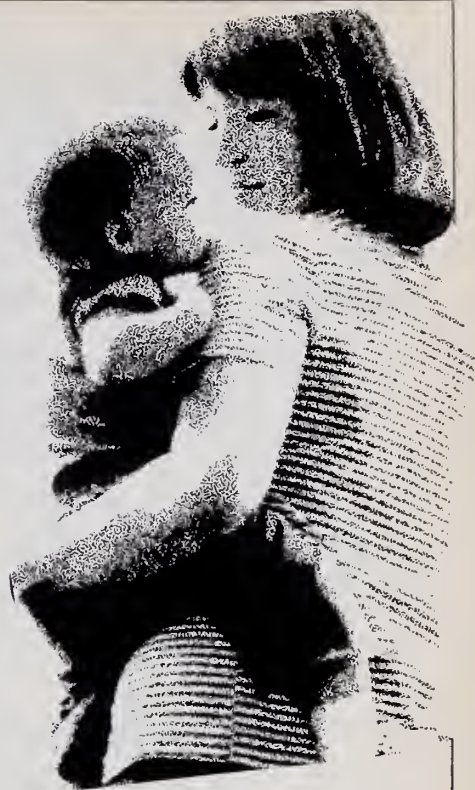
Often, these girls are using their pregnancy and subsequent motherhood as a means to get attention, to feel "grown-up."

"But actually, these girls end up feeling alone, frustrated, angry," she notes.

From her own experience working with teenage mothers at OSU's Pediatric Clinic, Dr. de Levie attests that communication between teenagers and health-care professionals is frequently poor — adding to the feelings of resentment and aloneness.

She offers the following advice to those doctors who work with "teenage parents" in their own practice.

- Encourage communication. "Teenagers are often afraid to ask questions and they won't volunteer information on their own," says Dr. de Levie. "At least, not initially." But her own personal observations have taught her that some doctors, and especially medical students and residents, can be just as guilty. "If they see that this is not a (typical) family unit,



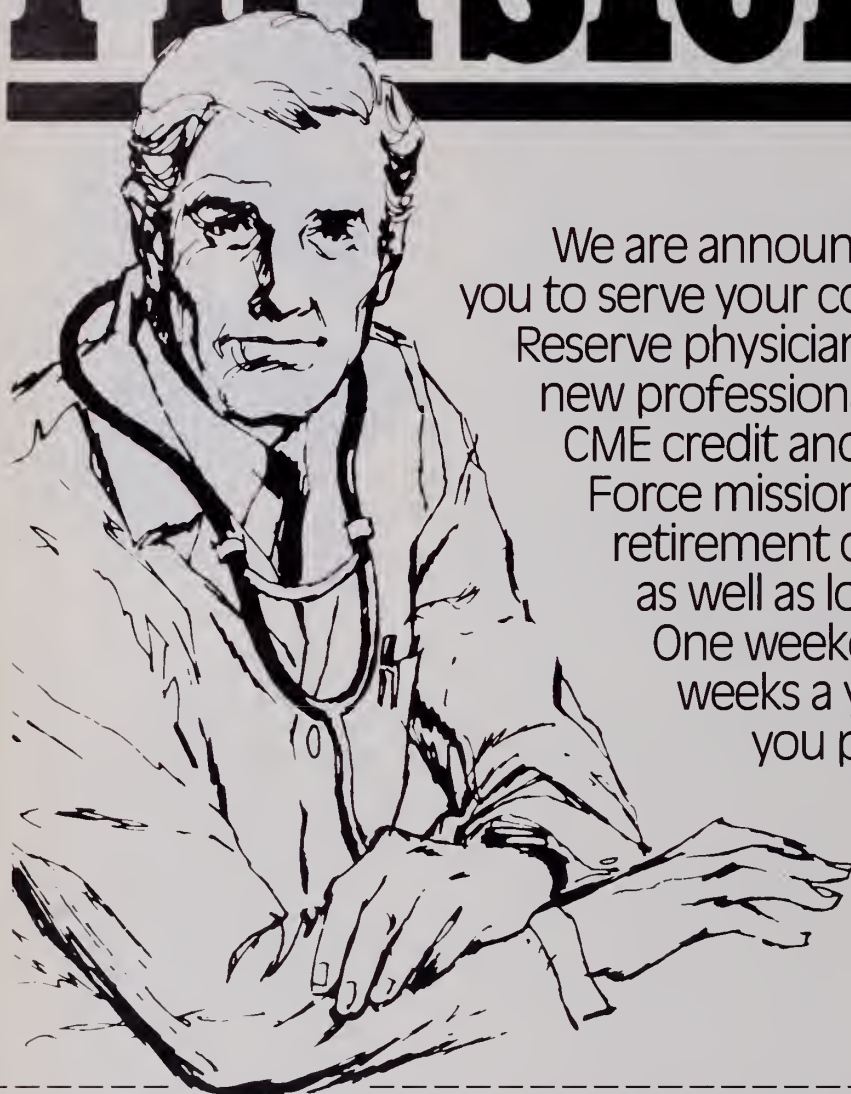
they may feel it's better not to ask questions," she says, so communication often becomes stilted or, worse, non-existent. "Ask if the father sees the baby, about the father's involvement with the mother, ask if the patient is on birth control." It's too easy, she says, to just see the mother and the baby, "without seeing the whole constellation of family."

- Involve the father. It seems to be the exception rather than the rule that brings teenage fathers to their infant's exam, but if they do come to the clinic or to your office, invite them back, says Dr. de Levie, and keep involving them in the care of the baby. "Maternal grandmothers are often anxious to cut the boys out once the baby is born," she says, adding that maternal grandmothers can often create a note of friction between the baby's mother and father. "The father's involvement is usually limited anyway," she says, so physicians should take special care not to limit that involvement even further.

- Encourage mothers to return to school, or to continue their education in some other manner — night school, for example, or

continued on page 83

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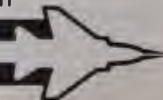
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Legislative Forecasts

By the OSMA Department of Legislation

January 1988, marks the halfway point of the 117th Ohio General Assembly. During the past year, more than 100 individual pieces of legislation and numerous governmental administrative actions have been actively reviewed by the Ohio State Medical Association's Department of Legislation. The second year of session for the 117th Ohio General Assembly will officially convene on January 5, 1988, and all of the legislation left pending in 1987 will be eligible for further review and consideration in 1988.

Although the 1988 session is expected to be brief, due to legislative elections for state Representatives and state Senators,

1988 is expected to be an intensive session. The remaining priority legislative proposals that the OSMA Department of Legislation will be closely monitoring in 1988 include: House Bill 150, mandatory medicare assignment; House Bill 149, chiropractic outpatient diagnostic privileges; and House Bill 543, health maintenance organizations. The legislative staff also anticipates the introduction of a comprehensive bill pertaining to AIDS issues and the introduction of legislation on indigent care.

All legislation introduced is carefully scrutinized by the OSMA legislative staff and the OSMA Committee on Legislation to

Past Presidents Predict . . .



"The three A's of a successful practice still determine a physician's capacity to influence political issues. Availability, Affability, and Ability, are the order of importance in which patients measure their respect and affection for their physicians.

"Patients are the physician's political constituency; deserve and keep their respect and affection. They will then in turn influence legislation as you wish.

"At this late stage in life my thoughts on patient care are perhaps more valuable than any concept I may have on pending political issues or problems.

"Doctor, your telephone is your front door; be sure that the one who answers it is committed primarily to patients' welfare rather than to your protection."

**—Frank H. Mayfield, MD
Cincinnati
OSMA President
1959 to 1960**

ensure it will not impair Ohio's physicians from delivering quality health-care services to the citizens of Ohio. The OSMA's Committee on Legislation was instrumental in reviewing the many bills affecting the practice of medicine and quality health care which were introduced during 1987. The OSMA's Legislative Committee is chaired by Herman I. Abromowitz, MD of Dayton. Members of this Committee include:

Janet K. Bixel, MD (Columbus)
John A. Burkhart, MD

(Columbus)

James A. Cottrell, MD
(Steubenville)

Nicholas G. DePiero, MD
(Garfield Heights)

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Edmond W. Gardner, MD
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Thomas J. Hall, MD (Newark)

Karen Guss-King, medical
student (Toledo)

Konrad F. Kircher, MD (Dayton)

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Albert L. Tsai, MD (Ravenna)

Rose Vesper, OSMA Auxiliary
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George F. White, MD
(Portsmouth)

Richard Wiseley, MD (Toledo)

The following article presents a synopsis of the major legislative issues considered by the Ohio General Assembly during 1987, as well as a prognostication of the fate of some issues which may reappear in 1988.

Medical Professional Liability Reform

During 1987, attention was given to many of the medically-related bills by both the Ohio House of Representatives and the Ohio Senate. Of these legislative proposals, the most significant issue to physicians was House Bill 327, a reform of the medical professional liability statutes. The success in the passage of this important bill, co-authored by state Representative Paul Jones of Ravenna and state Senator David Hobson of Springfield, effectively addressed those areas of medical tort law which needed some fine tuning in order to stabilize the medical professional liability marketplace in this state.

As simple as this achievement may sound, a recount of the legislative and political events which occurred prior to passage of House Bill 327 will emphasize the significance of the passage of this bill by organized medicine in a very volatile political environment.

Prior to the introduction of House Bill 327, the General Assembly had spent much time and energy on a general tort and insurance reform bill aimed at helping to alleviate the liability problems being encountered by various other professions and businesses. In 1986, the legislature passed what it believed was a carefully-crafted piece of general tort reform legislation which addressed the liability concerns of a broad spectrum of society. However, due to the pressures

exerted by the opponent groups, the Ohio Public Interest Campaign — a Naderesque consumer group — and the trial attorneys, Governor Celeste vetoed the general tort reform measure in December 1986. It was this sentiment that organized medicine had to overcome to gain the passage of a specific medical professional liability bill, House Bill 327.

A review of what had been legislatively achieved by medicine in tort reform almost a decade earlier provided the opportunity to identify the areas of Ohio law which needed attention to achieve the needed stability in a very narrow liability insurance market and to derail an impending liability crisis for Ohio's physicians, which was already occurring in other states.

Following six months of lengthy and intense negotiations on the part of the Ohio State Medical Association and representatives of opponent groups, such as the Ohio Public Interest Campaign and the trial attorneys, legislative leadership was able to formulate and pass a bill that was acceptable to both physicians and legislators. In the Ohio Senate, House Bill 327 was passed by a vote of 32 to 1. The bill also passed the Ohio House of Representatives by an equally-impressive margin of 83 to 7. The signing of the bill by the Governor on July 20, 1987, provided the final action necessary for House Bill 327 to become law in Ohio.

The statutory changes made by House Bill 327, notwithstanding a subsequent opinion by the Ohio Supreme Court regarding the statute of repose, provide help to ensure affordable and accessible medical professional liability insurance for Ohio's physicians. This is imperative so physicians can continue to deliver the high quality medical care Ohio citizens have come to expect and enjoy. Provisions of the bill, including

the one-year statute of limitations following discovery, mandatory periodic payments, the regulation of the frivolous conduct of attorneys, and the affidavit to reduce frivolous suits, are positive steps which will help to stabilize the medical professional insurance marketplace. Additionally, in order for the General Assembly to follow the impact of this bill on the liability market, a Malpractice Study Committee was created by the legislation. This Committee will monitor the impact of House Bill 327 and study common law and statutory provisions governing medical tort actions to determine if further statutory changes are necessary.

Organized medicine achieved more meaningful tort reform in House Bill 327 than any reforms ultimately achieved in the general tort reform proposal, House Bill 1. The organized, straight forward and professional approach taken by individual physicians and physician spouses must be credited for a great deal of this success. The impressive volume of letters and telephone contacts made by the Ohio physician community highlighted to the members of the General Assembly the importance of this issue to the physicians and in the best interest of their patients. This approach resulted in the passage of House Bill 327 without jeopardizing the medical profession's future access to the General Assembly for other important legislative campaigns. The accomplishment of this status was imperative because of the magnitude of other important medical issues remaining before legislative bodies.

In addition to the passage of House Bill 327, the Ohio Supreme Court's decision, *Hardy v. VerMeulen*, had the second most profound effect on medical professional liability in Ohio. The opinion issued by the Supreme Court in this case struck down the Ohio law enacted in 1975 which

Past Presidents Predict . . .

“ ‘Land of the Free’? Not without freedom of choice. ‘Home of the Brave’? Not without a good computer or an attorney. What is ethical in maintaining a life but destroying a family? The papers are replete with tales of such medical technological triumphs. Is there compassion in payment in advance? Physicians must be ordered to take care of AIDS? Indeed!’ ”

**—Lawrence C. Meredith,
MD (retired)
Bowling Green, Kentucky
OSMA President,
1966 to 1967**

Past Presidents Predict . . .

"Predictions overall: Since 1988 is an election year, little of importance will be enacted although much may be proposed for political posturing. Now, for three specifics. In view of the budget crunch, the increase in part B premium of 38%, and the reported 6.5% increase in physician income, legislation will be proposed to cap Medicare, and/or enact compulsory assignment, and put RAPs under DGR.

"Second, when the resource-based RVG study is presented in June 1988, the long smoldering dispute between procedural and non-procedural physicians will flame into the open and will produce self-destructive testimony before the congressional committees considering implementation of an RVG for Medicare.

"Third, senior officials of HHS will continue to push capitation for Medicare services."

**—Robert N. Smith, MD
Toledo
OSMA President, 1969 to 1970**



required that a malpractice suit be filed within four years after the alleged malpractice occurred. In the opinion, the Ohio Supreme Court held, by a vote of 4 to 3, that the four-year statute of repose is unconstitutional in situations where the individual bringing suit claims that he or she did not discover the injury within the four-year time frame. Prior to this ruling, a medical malpractice case had to be brought within one year from the date the patient reasonably should have discovered the injury, with an absolute statutory limit of four years from the rendering of medical services.

For physicians, *Hardy v. VerMeulen* has given every patient an indefinite time period to file a malpractice case. Additionally, with every patient, all records of care are open for litigation for the life of the patient. The opinion is also expected to have a dramatic effect on medical liability insurance carriers who now must reserve for potential losses from medical malpractice suits over an

indefinite period of time. This endless exposure to the threat of a suit will most likely lead to an increase in the price of medical liability insurance and, inevitably, higher health-care costs.

Furthermore, legal experts are predicting that the logic the Court applied in ruling the malpractice statute of repose unconstitutional could very well be applied to other liability cases — such as personal injury and product liability. This could lead to higher insurance costs for everyone.

The opinion in *Hardy v. VerMeulen*, although specifically addressing the constitutionality of the timeliness of filing a medical malpractice suit, also made a significant statement as to the proper duties of the Ohio General Assembly. With the passage of House Bill 327, the General Assembly reaffirmed, as sound public policy, the four-year statutory limit for the filing of medical malpractice suits, which had been enacted originally in the mid-1970's. The Supreme Court

decision not only works to undermine the effectiveness of House Bill 327, but also diminishes the Ohio Legislature's ability to address a vital issue with the formulation of what is perceived to be appropriate public policy.

The majority of the Court has effectively set forth that the elected legislature cannot be responsive to issues which need a statement of public policy. Two of the three Supreme Court Justices, who disagreed with the majority opinion, made some very cogent arguments pertaining to the ultimate impact of the decision on the Ohio General Assembly. Justice Craig Wright, in his dissenting opinion, stated, "Without question, today's holding creates a constitutional dilemma of severe proportions. The Court has informed the General Assembly it has no power to meet what it perceives as an epidemic crisis with responsive legislation." He went on to say

continued on page 25



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The World's Most Popular K*

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potassium chloride
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8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

The World's Most Popular K

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Slow-K[®]
potassium chloride
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For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiaro SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiaro SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K[®]
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see **OVERDOSSAGE**).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See **OVERDOSSAGE**).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see **WARNINGS**.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS, and OVERDOSSAGE**). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS and WARNINGS**), other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS and WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-spanning diuretics; (2) intravenous administration of 300-500 mEq of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100 NDC 0083-0165-30

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Consumer Pack—One Unit

12 Bottles—100 tablets each NDC 0083-0165-65

Accu-Pak[®] Unit Dose (Blister pack)

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Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP)

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that because the majority of justices disagree with the statutory time constraints under the 1975 medical malpractice statutes, the Supreme Court has "under the guise of judicial interpretation, abrogated the function of the General Assembly and the electorate by amending the Constitution by judicial fiat."

Additionally, Justice Robert Holmes, in his dissenting opinion, stated, "The public policy of the state has been expressed by the General Assembly as it related to the need for a statute of repose in medical malpractice actions and had resulted in enactment of Revised Code 2305.11 (B). This act of the legislative body of Ohio was carried out after a specific pronouncement of a medical malpractice crisis in this state, and upon a multitude of legislative hearings declaring this to be the public policy in Ohio. This Court, in determining that such legislation is unconstitutional, not only carries out a needless task, but it sets itself (Ohio Supreme Court) apart as a super legislative body usurping the very constitutional prerogatives of the General Assembly."

The access to the legislature maintained throughout the legislative agenda on House Bill 327 will assist in any legislative effort which may be proposed to respond to the current situation. Some legislators have commented that they received numerous letters from physicians thanking them for their support for the OSMA's medical professional liability reform bill, House Bill 327. Staff has used this opportunity to discuss with legislators the impact which the Ohio Supreme Court decisions may have on the medical professional liability market in Ohio.

The OSMA is aggressively pursuing possible alternatives to address the damage done by the Ohio Supreme Court's decision. Even though the Court's opinion

was directed to the 1975 law, it severely compromises the reaffirmation of the statute of repose in House Bill 327. With the opinion establishing the unconstitutionality of a statute of repose, some option other than a statute of repose must be considered at this time. To date, no specific alternative has been determined to be the best answer, but any resolution to this matter must equally maintain the rights of the patient and the physician. It is grossly unfair that either party carry an extraordinary burden — it is imperative that the delicate balance established by House Bill 327 be regained.

General Tort Reform

In late September 1987, the Ohio House of Representatives and the Ohio Senate held one-day sessions for the purpose of passing House Bill 1, the general tort reform and insurance regulation bill, which Governor Celeste vetoed one year ago. On October 5, Governor Celeste quietly signed House Bill 1 into law. The new law, which contains some tort reform provisions that may benefit physicians, became effective on January 5, 1988. The provisions of import to physicians include:

1. raising the standard for awarding of punitive damages from "preponderance" to "clear and convincing" evidence;
2. taking from juries and giving to judges the authority to determine the amount of punitive damage awards, which should have the effect of reducing punitive damage awards;
3. permitting defense attorneys to speak with other attending physicians who are not defendants in the claim during the discovery process rather than waiting until the trial begins, as is now the law.

The mandatory periodic payment provision contained in

House Bill 327, OSMA's medical professional liability reform bill, is superior to a similar provision in House Bill 1 and will not be affected by House Bill 1. Also, the collateral source provision and the \$200,000 cap on non-economic damages currently contained in Ohio's medical liability statutes will not be affected by similar provisions in House Bill 1.

Mandatory Assignment

House Bill 150, the mandatory Medicare assignment legislation, is still pending in a subcommittee of the Ohio House Aging and Housing Committee. The subcommittee has not met on House Bill 150 since May 1987, when hearings were held on the legislation in Cleveland and Columbus.

House Bill 150, sponsored by state Representative Barbara Pringle of Cleveland, would provide that the State Medical Board require, as a condition of granting or renewing a certificate of registration, that a practitioner who agrees to provide health services to individuals under the Medicare program also agree not knowingly to charge to or collect from any individual any amount in excess of the Medicare reasonable charge for such service. This bill would also include under the reasons for which a physician or podiatrist may have his/her certificate limited, revoked or suspended, knowingly charging to or collecting from an individual an amount in excess of the Medicare reasonable charge for a health service the practitioner agreed to provide to the individual under the Medicare program.

The sponsor of House Bill 150 has stated that she plans to offer a substitute version of House Bill 150. The proposed substitute version of the bill would remove the current language in House Bill 150 and prohibit a physician, osteopath or podiatrist, who provides a health service for a

Past Presidents Predict . . .

“Legislative issues which may be raised or considered in 1988 will be increased control by government of physician fees and independents. The pressure by government and insurance companies will promote greater control of medical practice. Malpractice insurance will continue to be a major problem. We, as physicians, must continue a united front to educate patients, all the public and industry — speak up for medicine, and promote legislation to be sure the quality of medical care is *not* sacrificed in the name of earnings.”

**—William R. Schultz, MD
Groveport
OSMA President,
1972-1973**

Medicare patient, from knowingly charging to or collecting from a Medicare patient an amount in excess of the Medicare reasonable charge for that service if the patient belongs to a household in which the total income for the preceding year was \$9,000 or less. The proposed substitute version of the bill would place the responsibility on the physician, osteopath or podiatrist providing the Medicare health service, to ascertain which Medicare patients

receiving Medicare services belong to the specified income category.

Finally, the proposed substitute version of House Bill 150 would establish that alleged violations may be reported to the State Medical Board. The State Medical Board would then be required to investigate the allegation and upon a finding that a violation has occurred, the State Medical Board would be required to hold a hearing and then could impose a \$2,000 fine upon the physician, osteopath or podiatrist.

State Representative Pringle's office claims the substitute version of this bill would no longer threaten violators with the loss of their medical license; however, this does not appear to be the case. Under existing grounds for disciplinary action in the law, the State Medical Board has the authority to limit, revoke or suspend a certificate, refuse to register or refuse to reinstate an applicant, or reprimand or place on probation the holder of a certificate for "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board."

Although state Representative Pringle's office has publicly stated that the changes in House Bill 150 are in response to the many letters she has received from physicians, the changes in the substitute version of House Bill 150 do not represent a negotiated compromise, and the Ohio State Medical Association remains actively opposed to this bill.

U.S. Supreme Court Refuses to Hear Massachusetts Mandatory Assignment Case

On October 13, 1987, the United States Supreme Court declined to review the Massachusetts mandatory Medicare assignment case. In June 1986, the U.S. District Court upheld the

constitutionality of the Massachusetts medical practice statute requiring that as a condition of licensure to practice medicine, a physician who agrees to treat a Medicare beneficiary must also agree not to charge to or collect from such beneficiary any amount in excess of the Medicare determined fee for that service. The Massachusetts Medical Society and the AMA appealed this decision to the U.S. Court of Appeals for the First Circuit, which affirmed the decision of the U.S. District Court. The Massachusetts Medical Society and the AMA then appealed the decision to the U.S. Supreme Court.

In declining to review the case, the issue of the validity of mandatory assignment legislation outside of the First Circuit is left open because the U.S. Supreme Court expressed no view about the constitutionality of the Massachusetts' law. The states of Massachusetts, Maine, New Hampshire, Puerto Rico and Rhode Island are included in the First Circuit. Legally, this court decision does not directly impact the Ohio legislation, since Ohio is in the Sixth Circuit; however, the validity of mandatory assignment legislation outside the First Circuit is left open.

Washington State Rejects Mandatory Assignment

In 1986, legislation which provided for the acceptance of mandatory assignment on the basis of a means test was defeated by the Washington state legislature. With the defeat of the Washington legislation, a constitutional initiative was launched by the Washington State Labor Council, the Puget Sound Council of Senior Citizens and various other organizations to provide that it would be a violation of the state's Consumer Protection Act for physicians treating Medicare eligible patients to charge more

than Medicare's reasonable charges. The initiative received the necessary signatures to be placed on the ballot for the November 3, 1987 election and was soundly defeated by the voters.

Congratulations are in order for the Washington State Medical Association, since it waged an extremely effective campaign against the initiative.

Mandatory Assignment Legislation Passes in Vermont, Rhode Island and Connecticut

Besides Massachusetts, some type of mandatory assignment legislation has passed in Vermont, Rhode Island and Connecticut. The state legislature in Vermont enacted mandatory assignment legislation in May 1987, similar to that enacted in Massachusetts, except the Vermont legislation does create certain minor exceptions to the prohibition on balance billing.

Connecticut became the third state to enact Medicare assignment legislation; however, Connecticut's law statutorily recognizes the Connecticut State Medical Society's¹ voluntary courtesy card program, which issues medical courtesy cards to individuals based on an annual income level.

The Rhode Island statute is also based on a means test and physicians must accept the Medicare determined amount as payment in full for those Medicare patients who present a card indicating their eligibility for the state's pharmaceutical assistance program for the elderly. In Rhode Island, the legislation will sunset after one year and then a study commission will look into all matters relating to mandatory assignment.

Allied Practitioners

A number of bills have been introduced this session that concern allied practitioners. **House Bill 529**, which revises the Nurse Practice Act, has passed the Ohio House of Representatives and

should be heard by the Ohio Senate Health, Human Services and Aging Committee in January. The bill, as passed by the Ohio House of Representatives, is supported by the Ohio State Medical Association; few changes to the bill are expected in the Ohio Senate. House Bill 529 would redefine the scope of practice for both registered nurses and licensed practical nurses; would revise the composition of the State Nursing Board; would provide for peer support programs and continuing education requirements for nurses; and expand the grounds for disciplinary actions by the State Nursing Board.

Bolstered by a recent Illinois court decision, the Ohio State Chiropractic Association has announced it will try to pass a state law giving chiropractors the right to admit patients to hospitals. In late August 1987, a Chicago federal judge issued an opinion in *Wilk v. AMA* finding that the AMA had engaged in an unlawful conspiracy to restrain trade by means of a boycott of chiropractors. As a result of this decision, the Ohio State Chiropractic Association has retained a public relations firm in hopes of capitalizing on the Illinois court decision, and they have been meeting regularly to develop an aggressive state legislative program.

It is anticipated that the chiropractor's legislative program will focus on **House Bill 149**, which would require hospitals to grant chiropractors access to outpatient diagnostic procedures. House Bill 149, sponsored by state Representative Barbara Pringle of Cleveland, is currently pending before the Ohio House Health and Retirement Committee. The Ohio State Chiropractic Association would like to pursue passage of a state law requiring hospitals to allow chiropractors to have admitting privileges.

Also seeking hospital staff

Past Presidents Predict . . .

"Surely an active political thrust must be made to change the Supreme Court's Statute of Repose decision. This decision directly affects the manner in which medical care is delivered in Ohio. If at all possible, the Supreme Court must be made aware of the consequences of this action. Patently, it will affect the quality of medical care adversely."

— **James Henry, MD**
Grove City
OSMA President,
1974-1975

privileges are the psychologists. State Representative C.J. McLin of Dayton has introduced **House Bill 460**, which would prohibit the governing board of any hospital from discriminating against a psychologist in acting upon applications for staff membership and privileges. This bill is currently pending in the Ohio House Health and Retirement Committee.

The Ohio Dental Association is promoting the passage of **House**

Past Presidents Predict . . .



"It would be surprising indeed if either State or Federal Legislatures did not raise the issue of or involve themselves in what they perceive to be the continued high cost of health care, as well as the cost impact of nursing home care on the elderly. These two bodies will likely show increased interest in professional liability issues and at the federal level will rethink Medicare and Social Security costs."

**—George N. Bates, MD
Toledo
OSMA President,
1976-1977**

Bill 526, which is sponsored by state Representative Paul Jones of Ravenna. This bill would revise certain provisions in the Ohio Dental Practice Act, including the issuance of a permit for dentists who use conscious intravenous sedation. House Bill 526 is pending in the Ohio House State Government Committee.

Senate Bill 176, which has been voted out of the Ohio Senate Health, Human Services and Aging Committee, would provide for insurance payments for services of mechanotherapists. This bill, sponsored by state Senator Grace Drake of Solon, has not been voted out of the Ohio Senate yet.

Also sponsored by state Senator Grace Drake is **Senate Bill 300**, which would provide for the licensure of respiratory therapists. Senate Bill 300 would also create a five-member Ohio Respiratory Therapy Board. Hearings on this bill are expected to begin in the Ohio Senate in January.

A bill requiring registration of homemaker-home health aide agencies which accept state funds and operate in a county with a population of 65,000 or more was introduced in 1987 by state Representative Paul Jones of Ravenna. The bill, **House Bill 257**, resides in the Ohio House Health and Retirement Committee.

The Ohio Chapter of the American Physical Therapy Association will have legislation introduced in the Ohio House of Representatives in January to prohibit licensed health-care professionals, except licensed MD's and DO's, from designating services as physical therapy.

AIDS Legislation

Seven individual pieces of legislation have been introduced in 1987 on AIDS and other contagious diseases. **House Bill 199**, sponsored by state Representative John Stozich of Findlay, would require blood tests for marriage license applicants.

House Bill 212, sponsored by state Representative Marie Tansey of Vermilion, would prohibit a hospital from releasing a body of a person who died of or was under treatment for AIDS or any other contagious disease, to a funeral director until the funeral director acknowledges in writing he has been informed of what the person died from. **House Bill 551** would require a coroner to perform one or more laboratory tests for human immunodeficiency virus antibodies on bodies taken charge of by coroners. House Bill 551 is sponsored by state Representative Don Gilmore of Columbus. House Bills 199, 212 and 551 are currently pending in the Ohio House Health and Retirement Committee.

House Bill 538, also sponsored by state Representative Don Gilmore, would require an employee of a food service operation to take a blood test annually to determine whether the applicant for a food handler permit has an infectious or contagious disease. This bill has been referred to the Ohio House State Government Committee.

House Bill 571, which has been referred to the Ohio House Judiciary and Criminal Justice Committee, would prohibit any person with AIDS from selling or donating blood to another individual. House Bill 571 is sponsored by state Representative Larry Adams of Marion. **House Bill 627**, sponsored by state Representative Eugene Byers of Loudenville, would require human immunodeficiency virus testing for marriage license applicants, health-care professionals, persons employed by health-care professionals, persons employed in health-care facilities, food service operation employees, and persons sentenced to penal institutions. As yet, this bill has not been assigned to a committee.

In the Ohio Senate, **Senate Bill 258** has been introduced by state

Senator Bob Ney of Barnesville. Senate Bill 258 would require the attending physician or coroner, who signs the medical certificate of death of a deceased person who had the presence of a contagious or infectious disease, to notify the funeral director of the disease prior to receipt of the body. Senate Bill 258 has been referred to the Ohio Senate Health, Human Services and Aging Committee.

A fourteen-member legislative AIDS Task Force, chaired by state Senator David Hobson of Springfield, has been meeting on the various issues surrounding the AIDS issue. Other legislators serving on this Task Force include state Representative Paul Jones of Ravenna, state Representative Robert Doyle of Beavercreek, and state Senator Michael White of Cleveland. Physician members of this Task Force include Ohio State Medical Association members Carlos Andarsio, MD, of Springfield, Earl Freimer, MD, of Toledo, and Leonard Calabrese, DO, of Cleveland. The legislative task force is expected to issue recommendations for legislation in January.

The Ohio Department of Insurance has also appointed an AIDS Task Force, which has been meeting since the beginning of August 1987, on the issues of insurance company health screening for AIDS, AIDS testing, the confidentiality of AIDS test results, the constitutional equal protection rights of insurance applicants, and AIDS underwriting criteria. The Director of the Ohio Department of Insurance, George Fabe, has asked the Task Force members to develop a report and recommendations regarding these AIDS issues for the Department and the Governor, and to include recommendations regarding whether the Department should promulgate rules or seek legislation. OSMA physician members serving on the Insurance Department Task Force include

Carlos Andarsio, MD, A. Robert Davies, MD, Ian A. Scott, MD, Robert Wall, MD, and Joan Wurmbrand, MD. Carolyn Towner, of the legislative staff, has also been serving on the Task Force. It is anticipated that the Ohio Department of Insurance's AIDS Task Force will have its recommendations to the Director in early January.

Alternative Treatments for Breast Cancer

House Bill 215, which would require a physician to provide information on the alternative treatments for breast cancer and to explain the treatment options prior to a patient consenting to treatment for breast cancer, will begin hearings again in January. This bill, sponsored by state Representative Francine Panehal of Cleveland, would also require a patient to sign a "consent for breast biopsy" form and a "consent for breast surgery" form prior to an operation for a tumor of the breast and would create a Cancer Treatment Advisory Committee to assist the Ohio Department of Health in preparing a standardized written summary on the alternative treatments for breast cancer.

In response to **House Bill 215**, the Ohio Chapter of the American College of Surgeons has prepared a brochure "Breast Cancer: Diagnosis and Treatment Information." Copies of this brochure have been sent to all members of the Ohio State Medical Association, and additional copies can be obtained by contacting the Ohio State Medical Association. This brochure and the diligent efforts of the Ohio Chapter of the American College of Surgeons is an excellent example of physicians being proactive on an issue in order to demonstrate to the Ohio General Assembly that there are non-regulatory remedies to perceived problems. Copies of the

Past Presidents Predict . . .



"A most pernicious legislative proposal has already been submitted to the Ohio legislature in the form of House Bill 150. This bill would link licensure with mandatory Medicare assignment by requiring physicians, as a condition of receiving or renewing a license, to agree not to charge Medicare beneficiaries more than the charge deemed reasonable by the Secretary of Health, Education and Welfare. This legislation has been proposed in many states since it was judged constitutional in Massachusetts and has even included linkage to hospital staff privileges in some instances. This is a blatant attempt to utilize medical licensure, which should be related solely to physician competence, as a mechanism to implement social policy."

**—Thomas W. Morgan, MD
Gallipolis
OSMA President,
1979-1980**

Past Presidents Predict . . .



"Locally, I believe there will be increasing pressure within the state legislature to have physicians accept Medicare assignment. Some legislators will attempt to have this practice tied to licensure as is present in the state of Massachusetts. Although I do not expect such a measure to pass in 1988, there will be increasing pressure for reform in this area.

"As more HMOs and PPOs reject Medicare contracts, there will probably be some increasing pressure on them to accept Medicare reimbursements as determined by the government. I would expect increasing lobbying to have expanded activities for nurses and other non-physician professionals. These are two primary issues which have surfaced many times over the past, and will continue to be a source of difficulty for physicians. Unfortunately, I continue to see even darker clouds on the political horizon. I still believe we are fortunate to have the effective Legislative Department at the Ohio State Medical Association and, indeed, the whole society working to fight our battles for us."

—Stewart B. Dunsker, MD
Cincinnati
OSMA President, 1981 to 1982

brochure have been given to state Representative Francine Panehal, the sponsor of House Bill 215, and copies are being sent to all state legislators.

Members of the Ohio Chapter of the American College of Surgeons have also been extremely helpful in being available to testify on House Bill 215 and to meet with members of the Ohio House Aging and Housing Committee, which is hearing this legislation. Chapter members who have testified before the legislative committee include Richard Reiling, MD of Dayton, John P. Minton, MD of Columbus, Prabir Chaudhuri, MD of Toledo, and Margaret Dunn, MD of Dayton.

HMO Legislation

This past year, **House Bill 543**, a bill revising Ohio's HMO laws,

was the subject of extensive negotiations among the Ohio Department of Health, the Ohio Department of Insurance, the Ohio Department of Human Services and the Ohio HMO Association. The OSMA closely monitored the negotiations and participated in several issues of special interest to physicians. In December, the bill's sponsor, state Representative Michael Stinziano of Columbus, received a report on the negotiations. Hearings on a new draft version of the House Bill 543 are expected to be slated for January 1988.

Certificate of Need

Ohio's certificate of need (CON) program was extended for two years by passage of **House Bill 499**, authored by state Representative Paul Jones of

Ravenna, prior to the Legislature's recess in late June. Faced with a deadline imposed by the scheduled expiration of the CON program on June 30, 1987, the General Assembly expedited passage of House Bill 499 to assure continuance of the program.

OSMA achieved several notable changes in House Bill 499 as it was being considered by the Legislature. As introduced, the bill would have subjected physicians' offices to CON review because it would have required review for "any person" expending \$1.5 million for capital improvements or \$500,000 in operating costs to provide a new health service. OSMA succeeded in exempting physicians' offices by making those triggers applicable to "health-care facilities" rather than to "any

continued on page 33

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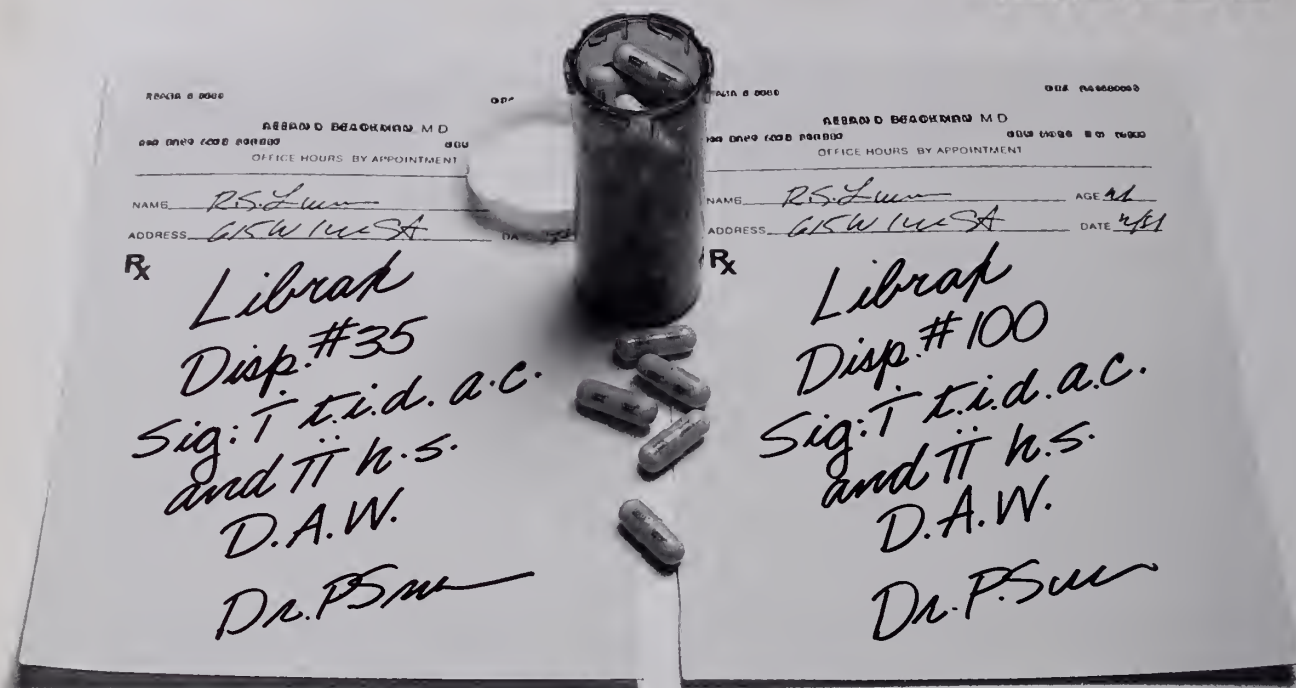
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person.” Physicians’ offices are specifically exempt from the statutory definition of a “health-care facility.” However, any acquisition of medical equipment valued at \$750,000 or more would be subject to review regardless of location.

OSMA also was successful in having the bill altered to clarify a provision which would have required review of any expenditure, regardless of the amount, for megavoltage radiation therapy services. An OSMA amendment clarified that the review applies only to those megavoltage radiation therapy services operated by or on behalf of a health-care facility.

House Bill 499 took effect on June 30, 1987, and will remain in effect until June 30, 1989. In September, the Governor appointed Albert Tsai, MD, a physician from Ravenna, to the new nine-member CON Review Board which will hear CON appeals.

During the last few months, the OSMA has been working with the Ohio Department of Health and interested physicians as the administrative rules are being promulgated to implement this new CON law.

Regulation of the Disposal of Infectious Medical Waste

House Bill 550, sponsored by state Representative Sam Bateman of Milford and **Senate Bill 243**, authored by state Senator Gary Suhadolnik of Parma Heights have been introduced to establish regulations for the disposal of infectious solid wastes. The Ohio State Medical Association was successful in having an exemption included in both bills to exempt physicians who generate less than fifty pounds of infectious waste per month. However, the small generator exemption has been opposed in legislative hearings by the Ohio Hospital Association, the Ohio Department of Health, and the National Solid Waste

Management Association.

House Bill 550 has been assigned to a subcommittee of the Ohio House Energy and Environment Committee. Members of the subcommittee include state Representative Jack Cera of Bellaire, Chairman of the subcommittee, state Representative Casey Jones of Toledo and state Representative John Stozich of Findlay. Carolyn Towner testified on behalf of the Ohio State Medical Association at the hearing held in the House and clarified to the subcommittee members what was and was not included in the small generator exemption. Ms. Towner explained that the exemption does not apply to the disposal of “sharps,” which would have to be disposed of in puncture-resistant containers, nor does the exemption apply to cultures, which would have to be disinfected prior to disposal in the regular waste.

As both bills undergo hearings in 1988, the Ohio State Medical Association will be working to keep the small generator exemption in both House Bill 550 and Senate Bill 243. Senate Bill 243 is pending in the Ohio Senate Energy, Natural Resources and Environment Committee, which is chaired by the sponsor of Senate Bill 243, state Senator Gary Suhadolnik of Parma Heights.

Medical Quackery

House Bill 393, sponsored by state Representative Ron Mottl of Parma, would prohibit an individual from offering, selling, dispensing, rendering, or administering drugs, substances, nostrums, medicines, processes, devices or treatments with the intent to defraud, or when that individual has knowledge or reasonable and substantial grounds to believe the drug, device, substance, nostrum, medicine, process or treatment is not effective as represented. House Bill

continued on page 37

Past Presidents Predict . . .



“I think the most critical issue facing medicine in 1988 will be how to maintain quality medical care in the face of rising practice costs and decreasing reimbursement levels. Insurance costs will go up as will the cost of running an office and the pressures from payors to reduce reimbursement levels will be much stronger. The federal government will place more obstacles in the way of the non-participating physician in an attempt to obtain universal participation in Medicare. We must continue to be the patient’s advocate and promote quality medical care.”

**—S. Baird Pfahl, MD
Sandusky
OSMA President,
1983 to 1984**



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Past Presidents Predict . . .



"Future issues affecting medicine should be judged more on the quality issue and not the economic issue. The apparent position of government and third-party payors for the past several years has been with economic concerns, while physicians, as the patient's strongest advocate, are attempting to stress quality as its prime issue. I endorse, whole-heartedly, OSMA President Dr. D. Ross Iron's advocacy that physicians should take charge for a change — always keeping in mind that we are physicians, concerned with issues which affect our patients' care."

**—Herman I. Abromowitz,
MD
Dayton
OSMA President,
1985-1986**

393 would also establish felony penalties for violations of the legislation.

As passed by the Ohio House of Representatives, House Bill 393 contains a number of exemptions from the provisions of this legislation for licensed health-care professionals in treating patients and in conducting research, for the treatment of human ills by spiritual means alone through prayer without the use of any drugs or other materials, and for persons licensed or inspected by a political entity and subject to the Ohio Pure Food and Drug laws.

It is anticipated that House Bill 393 will be vigorously opposed by health food stores and fringe practitioners when it begins hearing in the Ohio Senate Health, Human Services and Aging Committee.

Ohio Comprehensive Health Insurance Plan

House Bill 46, sponsored by state Representative Marc Guthrie of Newark, is expected to begin hearings in the Ohio Senate's Financial and Insurance Committee in 1988. As passed by the Ohio House of Representatives, this legislation would create the Ohio Comprehensive Health Insurance Plan to make health insurance coverage available to individuals considered uninsurable. House Bill 46, formerly called the Ohio Health Insurance Risk Sharing Plan, would be funded by the General Revenue Fund and health insurers would be assessed \$50 each to provide for start-up costs and would be assessed \$50 annually to defray the costs incurred by the Superintendent of the Ohio Department of Insurance in monitoring underwriting standards of insurers.

House Bill 46 provides that the supervision of the plan would be by a Board of Governors appointed by the Superintendent of Insurance. One member of the Board would be a licensed MD

and another member of the Board would be a licensed DO. The other members of the Board would represent insurers, a health maintenance organization, the public and hospitals. An insurer would be selected through a competitive bidding process to administer the plan.

Health Insurance

State Senator Charles Horn of Dayton introduced **House Bill 169** mandating that health insurance companies, health maintenance organizations, preferred provider organizations and others obligated to pay health-care benefits must pay providers within twenty-seven (27) days of receipt of a completed claim. Senate Bill 169 passed the Senate Financial Institutions and Insurance Committee and was sent to the Senate Rules Committee where, if approved, it will be voted upon by the full Senate.

Tobacco and Smoking

A half-dozen bills regulating tobacco products and smoking have been introduced in the Ohio General Assembly. State Senator Charles Horn of Dayton has authored two: **Senate Bill 51** would permit municipalities, townships and counties to regulate smoking in a more restrictive manner than state law; and **Senate Resolution 154** declaring the 117th General Assembly's support for a tobacco-free young Ohio by the year 2000. Senate Bill 51 has passed the Ohio Senate and was referred to the Ohio House Commerce and Labor Committee. Senate Resolution 154 was adopted by the Ohio Senate on May 6, 1987.

State Representative Ike Thompson of Cleveland, has introduced three tobacco measures. **House Bill 340** would prohibit distribution of free tobacco products and ban certain cigarette advertising. **House Bill 341** would restrict smoking in public places and **House Bill 456** would increase

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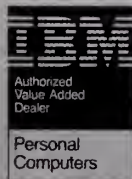
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the state cigarette tax and dedicate a portion of the cigarette tax to fund cancer research. House Bills 340 and 341 have been referred to the Ohio House Commerce and Labor Committee.

Senate Bill 193, authored by state Senator Richard Schafrath of Loudenville, would change the law by requiring smoking areas be designated rather than indicating no-smoking areas as is done now. This bill has been referred to the Ohio Senate Health, Human Services and Aging Committee.

State Senator Eugene Branstool of Utica introduced this fall **Senate Bill 282** prohibiting any person from using a tobacco product in any school building or vehicle owned by a school district. The bill has not yet been referred to a committee.

"Living Will" Legislation

Senate Bill 148, introduced by state Senator Robert Nettle of Barberton, is the current proposal before the 117th General Assembly which deals with the concept of a statutorily-recognized "living will." Senate Bill 148 is very similar to the bill reviewed during the 1985-1986 session of the Ohio General Assembly.

The current bill proposes requirements for the making and implementing of a "declaration of intent for a terminal patient" in Ohio. The legislation establishes immunity for physicians who comply with the "declaration" and the statutory requirements under which such a "declaration" would be valid. The bill also establishes procedures for situations where no "living will" document exists. House Bill 148 statutorily defines specific conditions for the withholding of life-sustaining treatment to be followed in situations where no "declaration" exists, but the patient is permanently unconscious.

House Bill 148 has been referred to the Ohio Senate Health, Human Services and Aging Committee. To

date, no hearings have been held on this measure.

Other Legislation

The following health-care bills passed the Ohio General Assembly in 1987:

- House Bill 1 — General Tort Reform and Insurance Reform, effective 1-5-88;
- House Bill 12 — Temporary Handicapped Parking Card, effective 9-10-87;
- House Bill 86 — Hospital Data Disclosure, effective 10-1-87;
- House Bill 171 — Biennial Budget, effective 7-1-87;
- House Bill 273 — Report Burn Injuries, effective 9-10-87;
- House Bill 301 — Long-Term Care Certificate of Need, effective 9-28-87;
- House Bill 327 — Medical Liability Reform, effective 10-20-87;
- House Bill 499 — Certificate of Need, effective 6-30-87;
- Senate Bill 98 — Certificate of Need Board Membership, effective 6-30-87;
- Senate Bill 122 — Correct Clerical Errors in Medical Practice Act, effective 4-2-87;
- Senate Bill 124 — Selective Contracting, effective 10-1-87;
- Senate Bill 196 — Medicaid Audits, effective 10-20-87;
- Senate Joint Resolution 8 — Mental Health, Alcoholism, and Chemical Dependency Treatment Task Force, adopted 5-6-87.
- Senate Resolution 154 — Support tobacco-free young Ohio by year 2000, adopted May 6, 1987.

The OSMA Department of Legislation staff: Rick Ayish, Director of Legislation; John E. Van Doorn, Director of State Legislation; and Associate Directors Kent Studebaker and Carolyn Towner.

(see related stories, next page)

Past Presidents Predict . . .



"One of the issues which I think physicians will be facing in the state legislature and national legislation in the year ahead is the continuing pressure for physicians to become participating or non-participating physicians under Medicare. I think there will be efforts made in the state legislature to again attempt to tie this in some way to licensure. We will have to be ever watchful to see that this does not occur as it did in several other states, particularly Massachusetts. Nationally, the budgetary crunch on the Medicare budget will have far-reaching impacts on both the hospital providing the medical care and the physicians involved with the delivery of the medical care."

—John E. Albers, MD
Cincinnati
OSMA President,
1986-1987

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Making Politics Work for Medicine

By the OSMA Department of Legislation

OMPAC — the Political Action Committee of the Ohio State Medical Association. As a partner to the OSMA's legislative effort, the Ohio Medical Political Action Committee (OMPAC) anticipates and reacts to the political environment and realities which prevail in Columbus and Washington, D.C. In response to the ever-changing challenges being placed on the medical profession by government at all levels, OMPAC is moving in an exciting new direction to address these challenges.

Every physician or physician spouse has felt the impact of legislative and regulatory decisions on the manner in which medical care is delivered. Each year, physicians face an ever-increasing number of challenges from the state and federal government which are aimed at changing or controlling the practice of medicine. Since January 1987, Ohio physicians have witnessed legislative activity in the Ohio General Assembly on some 100 bills which impact medicine, including the successful OSMA campaigns to reform medical professional liability statutes, and to derail the legislative push for mandatory assignment for Medicare services.

Additionally, competition in the political arena has never been

fiercer among health-care providers. Chiropractors, optometrists and psychologists, to name just a few, have become highly organized and are campaigning aggressively at the local grass roots level. With that support locally, their lobbyists are pressing for legislation expanding their scopes of practice.

The superb lobbying efforts of the OSMA, combined with individual physician and physician spouse grass roots activities, have many times made a difference in the decisions of government affecting the practice of medicine. However, with literally hundreds of health issues being deliberated both by the U.S. Congress in Washington, D.C. and the Ohio General Assembly in Columbus, this lobbying effort alone is not enough — physicians need to support the election of legislators who are willing to listen to and support the concerns of organized medicine. It is vitally important that organized medicine support legislators who share the views of medicine and who face increasingly expensive campaigns for public office. This expression of support is the primary role of OMPAC.

Since 1964, OMPAC has offered physicians and physician spouses the opportunity to become involved in the political arena and support, as a unified and bipartisan voice, those candidates

who understand the concerns of medicine. With physician and physician spouse involvement, OMPAC has been and can continue to be a significant partner with the OSMA's legislative effort.

OMPAC is one of the most active and influential professional action committees in this state and country. The successes of OMPAC-supported candidates in the 1986 general election highlight the keen understanding and involvement of OMPAC in political campaigns. Of the candidates supported by OMPAC for Ohio Senate seats in 1986, 95% were successful. The figure for the Ohio House of Representatives is even more impressive, with 99% of the OMPAC-supported candidates victorious. It is evident that active involvement of OMPAC can make a difference.

Although OMPAC has been successful in the past, it is currently looking to the future and charting a course of action for the challenges ahead. Membership in OMPAC has been sound enough in the past to keep medicine on an even keel with the significant issues facing Ohio physicians. However, in general, the same core group of approximately 2,000 physicians and physician spouses contribute to OMPAC. A remaining 10,000 plus OSMA-member physicians and their spouses do not participate in

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†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.

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Brief Summary Professional Use Information

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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

- Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In similar subacute hepatic studies,

oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy, Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), ostehenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

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Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Pelechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthralgia pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing.

References: 1. Schroeder JS. *Mod Med* 1982;50(Sept):94-116. 2. Cahn PF, Braunwald E. Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 3. O'Rourke RA. *Am J Cardiol* 1985;56:34H-40H. 4. McCall D, Walsh RA, Frohlich ED, et al. *Curr Probl Cardiol* 1985;10(8):6-80. 5. Frishman WH, Chorlap S, Goldberger J, et al. *Am J Cardiol* 1985;56:41H-46H. 6. Shapiro W. *Consultant* 1984;24(Dec):150-159. 7. O'Horo MJ, Khurmi NS, Bowles MJ, et al. *Am J Cardiol* 1984;54:477-481. 8. Strauss WE, McIntyre KM, Ponsi AF, et al. *Am J Cardiol* 1982;49:560-566. 9. Feldman RL, Pepine CJ, Whittle J, et al. *Am J Cardiol* 1982;49:554-559.

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OMPAC. If OMPAC is to meet the challenges facing physicians for the remainder of this decade and beyond, that level of participation must be improved.

Many physicians have become apathetic. Some feel change is inevitable and there is little they can do to affect change. Physician participation in the political process, especially OMPAC, has suffered as a result. In an increasingly sophisticated political world, the demands on OMPAC are becoming greater. Now more than ever, more physicians and physician spouses need to become involved.

OMPAC will be reaching out to physicians and physician spouses in the local communities, hospital medical staffs and specialty societies to become involved in OMPAC both statewide and in their local communities. With little time outside a physician's practice to devote to political activities, an investment in OMPAC is a significant contribution to the OSMA's legislative effort. The OMPAC Board is in the process of establishing local OMPAC Advisory Councils designed to assist the OMPAC Board of Directors in delivering the OMPAC message locally and conversely, these Councils will keep the Board member more attuned to the sentiment of the physician membership in the district.

OMPAC is looking to the physician community for both personal and financial support. Currently, the physician and physician spouse have two options for becoming Sustaining Members of OMPAC. First, an individual contribution of \$125 entitles the physician *or* physician spouse the opportunity of becoming an individual Sustaining Member. This entitles the OMPAC member to a 99+ lapel pin signifying Sustaining Membership, and the receipt of a quarterly newsletter, the OMPAC Report, which will keep the member up to date on current legislative/political activity.

IN MEMORIAM

State Representative Vernon F. Cook, a Democratic House member since 1972 and the assistant floor leader of the Ohio House of Representatives since 1979, died at his home in Cuyahoga Falls, Ohio, on November 23, 1987. Representative Cook, who was a friend of medicine and a close friend of the staff of the OSMA Department of Legislation, had been diagnosed as having cancer only five weeks before his death.

Representative Cook, 60, was an associate professor of political science at the University of Akron as well as director of the Ray C. Bliss Institute for Applied Politics, a school of politics located at the university. Representative Cook was the leader of the Summit County delegation in the Ohio House and was widely respected as an influential legislator whose counsel was sought by members of both political parties. Additionally, Representative Cook was considered one of the favored candidates to succeed



Speaker Vern Riffe as Speaker of the House.

In eulogizing Representative Cook, Speaker Riffe spoke of Representative Cook as a "dedicated, hard-working individual and his death is a personal loss to me. The Ohio General Assembly has lost a good member and I have lost a good friend." Representative Cook is survived by his wife Sharen; daughter, Julia Brashear of Cuyahoga Falls; and sons Richard, a student at Ohio University, and Thomas, at home.

Representative Cook will be missed by all.

Secondly, new for 1988, a Family Sustaining Membership category has been instituted, where a physician *and* physician spouse can both become full Sustaining Members with a single contribution of \$200, entitling both husband and wife the privileges of a full OMPAC Sustaining Member. A final option available only to a physician spouse is an Auxiliary Regular Membership contribution of \$35 which shows the physician spouse's support for OMPAC's cause.

The OMPAC Board of Directors is looking to the future of medicine and how OMPAC and the OSMA legislative effort can work hand in hand to ensure that Ohio's physicians are a viable entity in the world of politics. The 1988 election will be important to the entire medical community and

to OMPAC. Physicians and physician spouses, as Ohio voters, will be voting for all members of the Ohio House of Representatives, one half of the members of the Ohio Senate, all members of Congress, one U.S. Senator and two Ohio Supreme Court Justices. The officeholders elected will determine the structure of Ohio government and the environment for the practice of medicine for years to come. With so many decisions affecting medical care today being made by government, physicians and physician spouses cannot afford not to be involved in OMPAC, the political action committee of the OSMA. **YOUR INVOLVEMENT STRENGTHENS OUR VOICE.**

OSMA Department of Legislation

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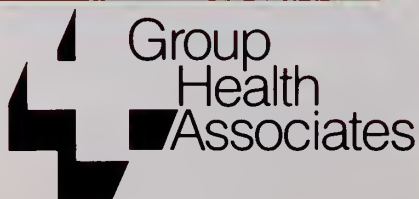
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Snapshots

An ethical look at AIDS

By Karen S. Edwards

Snapshots, sepia-toned and out-of-focus, tumble from Carol Levine's imaginary scrapbooks like dry, brown leaves from a winter sky.

She picks them up, slowly, one at a time, holding them up to view. Each is a testament of sadness . . . of anger . . . of fear.

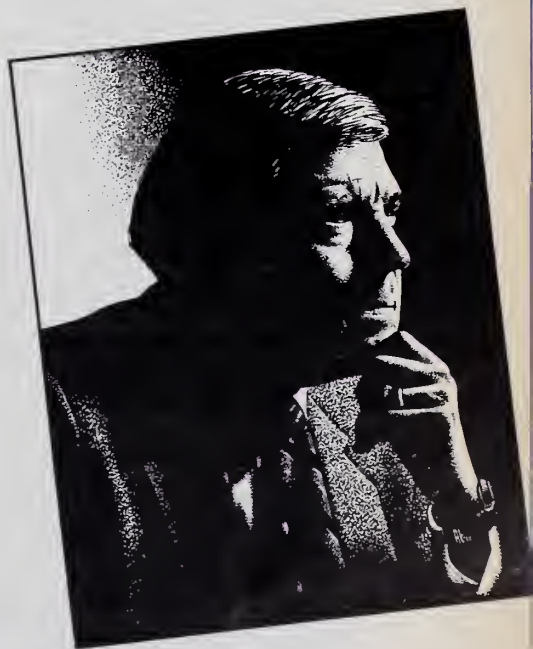
There is the boy in his 20s. Originally from a small town, he has landed in the big city — New York — with a lifetime of goals and hopes and dreams. But the dreams are never unpacked. Somehow, he contracts the AIDS virus, and the boy returns home . . . to die.

Another snapshot . . . an attractive woman . . . Hispanic . . . pregnant. But there is no proud, smiling papa at her side. Or even in the background. He is gone. Soon, she will be too. She has AIDS. Her family won't take her in . . . or the forthcoming child, so she is looking for a foster home . . . for someone who will love her baby, even though her baby, too, may contract the disease. But who . . . where can she find such a home . . . in such little time?

A man . . . middle-aged . . . respectable . . . a businessman, for heaven's sakes. He has AIDS and his doctor is telling him that, due to other professional responsibilities, he will be unable to see the businessman after today. The businessman checks with an attorney. Can his doctor do that? Sorry, the attorney replies, due to other professional responsibilities, he will be unable to answer the question. The businessman, despondent, sees a counselor. I need help, he says. The counselor agrees, but sorry, due to other professional responsibilities . . .

The snapshots with the kaleidoscopic patterns of faces, names, places and problems are not imaginary, insists Carol Levine. A bioethicist and editor of the prestigious *Hastings Center Report*, Levine was in Columbus recently as a keynote speaker for a program on AIDS, sponsored by the Commission on Interprofessional Education and Practice.

The "snapshots," the solitary images she paints with words instead of camera or brush, enable her to broach a subject not often



broached by *any* profession — and those are the ethical dilemmas which surround the issue of AIDS.

And what dilemmas there are! They arise in every area, in every walk of life, says Levine, especially challenging those professionals who perform best in a world of absolutes, of solid blacks and whites. It's not that physicians

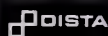
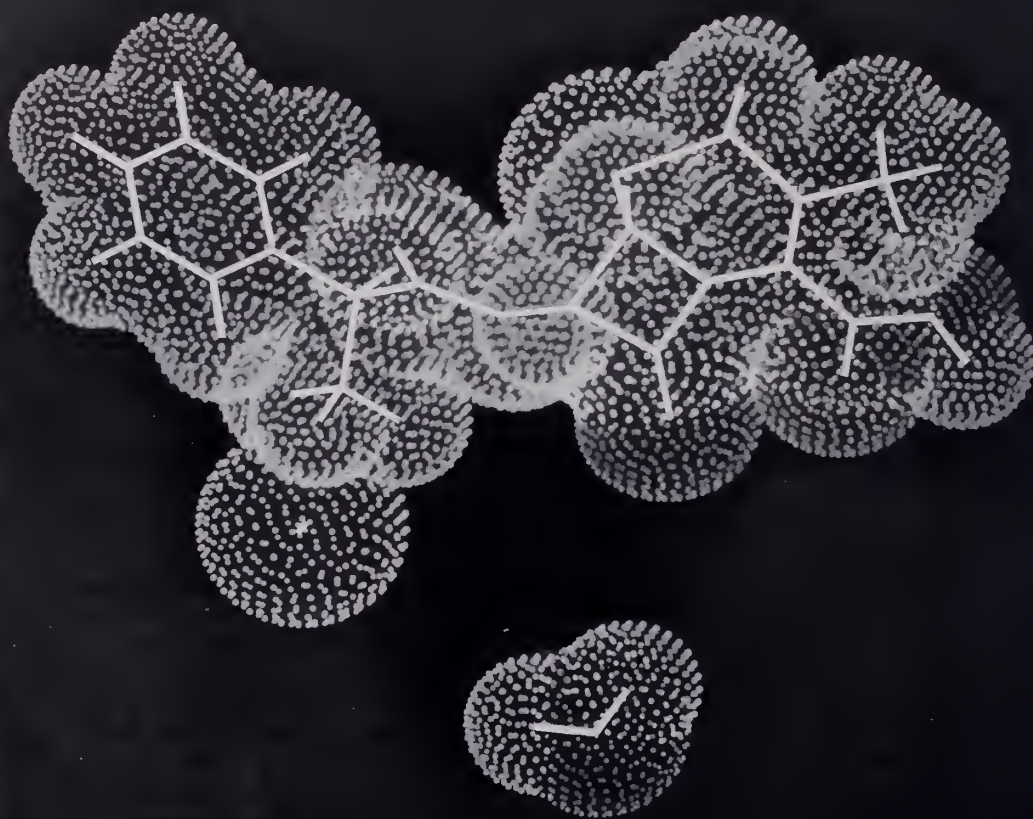
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aren't familiar (sometimes all too much so) with the blurry gray landscape of "ethics" — what's right and what's wrong. It's just that they move about that world as unsure of themselves as though they were thrust suddenly into a time where medicine is practiced without lasers . . . or scalpels.

"AIDS must be approached in a personal as well as a professional way," Levine chides, adding that "AIDS is more than an affliction of the body. It is a trial of the human spirit."

And it is the human spirit — or at least the humanness that exists in everyone — that is going to interpret the disease for future generations, despite the definition that the professions will ultimately assign it, she says.

How *will* AIDS be interpreted?

As Levine points out, there are a number of options.

"Because there is such a minority overrepresentation in AIDS — almost 40% of the IV drug users with AIDS in New York are blacks or Hispanics — it could be interpreted as a disease of poverty," she says.

But it could just as easily be a disease of young people . . . a disease of gays. Already, there are stigmas attached, she says.

"In the future, the division, socially, may be profound."

But look at the social and political context in which AIDS has emerged, she says. "It has come forward in a culture obsessed with sex; at a time when cutting costs has a greater priority than extending care."

In other words, the time, both socially and politically, is ripe for AIDS . . . the growth of AIDS.

"It is a catastrophic disease because there is such potential for disaster," Levine comments.

. . . And potential for more snapshots.

Picture a page in the *New York Times*. An obituary page, carrying tributes to young men. "He was surrounded by his family at the

time of his death," one of them reads. "He died in the arms of his friend," reads another.

"It is important for these people to announce they were not abandoned at the time of their death," says Levine.

Maybe because so many are.

With 150% underreporting of the AIDS virus among IV drug users in New York, it's not hard to estimate that for every case that is reported, there are many more who are dying silent and alone.

Some are preparing living wills, requesting that treatment be suspended when death is near.

"But the wills must be specific enough to be helpful," Levine points out. "Usually, there is some variation on what the patient really wants at the end. Some want every measure taken, every chance tried. Others want only to be left alone, to die in peace. The friend or family member who is appointed decision-maker needs to know what variation to choose."

In the meantime, the professions plod along, taking measures which create more ethical dilemmas . . . more snapshots.

There is testing, for example — and notification of sexual contacts.

"The questions public health needs to ask itself," says Levine, "are will it work, and at what costs?"

Testing is sometimes implemented for appearance's sake — because someone requested it, Levine says. "But if it is used appropriately, with counseling and proper follow-up, testing can be worthwhile," she says. Likewise, notification of sexual contacts "could provide information that we are presently not aware of."

However, she cautions that such tools be used as cost-effective measures — not punitive ones.

Research is another area that has brought up difficult-to-answer questions.

"For many AIDS victims, volunteering as a research subject

continued on page 47



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is the only therapeutic benefit they derive. But how can subjects be chosen equitably?" asks Levine.

And the FDA's response to pressure to release experimental drugs early (see related sidebar story) has created its own tough questions.

"The drugs are easier to obtain, but, where they once used to be free, now there is a charge — and rates vary. How equitable is that?"

Vaccines are another topic of debate, says Levine.

"Is it appropriate to skip animal models, since there is no good animal model available, and go straight to a test on humans? If so, how will you select the candidates? And will it become ethical to protect only those AIDS patients who got their antibodies in a "good" as opposed to a "bad" way? How will a vaccine be tested in a Third-World country, which desperately needs a vaccine, but where there is no informed consent?"

The subject of costs, too, comes more sharply into focus.

"Who will bear the burden of costs?" Levine asks. And how?

"We need more imaginary approaches for treating AIDS," she continues, adding that hospitals can only be beneficial to AIDS patients on an intermittent basis.

"More out-patient services are needed," she says.

But does that mean that special AIDS services will evolve? Special AIDS units in hospitals? Even special AIDS hospitals? And, if so, will these patients carry the stigma, the societal leprosy that clings to AIDS patients like stubborn, smothering vines? Treatment may be enhanced in these specialized facilities, Levine admits, but at what price? Separation from friends and family may be the cost.

And who will staff these hospitals?

"There is so much professional burn-out in treating AIDS patients," says Levine.

Replacements need to be found, but some young physicians are avoiding those big-city areas where AIDS is prevalent, she says. "It's ironic, because sooner or later, AIDS will catch up with them. It will be everywhere."

Right now, however, it's a problem that has been too long deferred.

"The pattern has always been that it's 'someone else's problem'," says Levine. She likens it to a classic textbook case of a patient suddenly confronted with his or her mortality.

"In the first stage, there is denial. The sense that this can't be happening," she says.

In the second stage, the patient panics — just as the first AIDS case in a practice, or hospital, or community is going to force reality from abject denial.

The third stage is a coping stage. The truth, the reality, is accepted and incorporated into the normal, functioning, day-to-day existence. Here, formal structures are often established to help deal with the situation.

Finally, there is burn-out . . . a sense of hopelessness and helplessness . . . and a very real need for increased emotional support.

"These stages are not sequential," says Levine. "They can occur in any order, or not at all."

It is the final stage, the burn-out phase, that Levine believes raises the most concern.

Education may help she says. It may be just what is needed to bring the real and perceived risks of working with AIDS patients back into perspective.

"It's been shown that there is a low occupational risk for health-care workers — in fact, the risks of getting AIDS and dying from it

are smaller than the risks of getting and dying from hepatitis-B."

However, fears and prejudice continue . . . like snapshots.

Picture a physician with two patients. One has leukemia. The other has AIDS.

"Surveys show that a physician is going to give more support to the leukemia patient," says Levine.

Why?

"It's unpleasant for a professional to fail," she points out — and it's clear no one is going to win any cases against AIDS. Too, there are few financial rewards or recognition for those professionals who treat AIDS patients. *And* there is prejudice.

"Professionals should acknowledge their attitudes about sex, age, and so on," says Levine. But balance those feelings with professional responsibility, she cautions.

"Much of the answer to the ethical dilemma of AIDS is going to depend on the flexibility of the health-care system and the willingness of professionals to devote themselves to the tasks at hand," she continues.

Education as pointed out earlier may help.

"Education is all we have," says Levine. But maybe not. Maybe there are *other* snapshots out there — blurry and indistinct now, but coming into focus.

Picture professionals — nurse, doctor, social worker, psychologist — working together to combat AIDS — a combined effort of caring, concern, support. Picture the ethical dilemmas that swoop and soar over the AIDS virus dissolving . . . slowly ebbing.

Picture them gone. **OSMA**

Karen S. Edwards is the Executive Editor of OHIO Medicine.

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Treating Your Practice — II

Making Each Patient's Visit A Positive Experience

By the Department of Communications and Physician Marketing

Once a patient has chosen to make an appointment with you, your next challenge is to make sure that he or she will be treated in such a way as to want to return to you again when health-care problems in your area of specialty arise. A variety of factors go into making a patient's visit with you a positive experience. In addition to the face-to-face contact he or she has with you, the physician, the patient's ease in finding your office, comfort level in your waiting room, interactions with your staff and time spent waiting to see you all have an impact on how that patient feels about you

and your practice — and whether or not he or she will consider a return visit.

The following are some tips on helping patients to have a pleasant visit with you:

Building Location and Office Decor

Your office should be located within close proximity of the patients you wish to attract. If you are a pediatrician, for example, it should be accessible not only to neighborhoods with young children, but also to locations where child care, day care and preschools are located.

If you lease your office, insist that the building be kept clean and in good repair. Grounds should be cut and landscaped in the summer; parking lots and sidewalks should be cleared of ice and snow in the winter.

Parking areas should be visible and easily accessible to the public. If older patients make up a large part of your practice, it may help to be on a public transportation line.

Remember, most health-care decisions are made by women — for themselves, their children and their spouses. Ironically, however, most physicians' waiting rooms appear to

Remember, most health-care decisions are made by women — for themselves, their children and their spouses.

be designed for men, with vinyl furnishings, hunting prints, etc. Try to make your decor appeal to both sexes.

For a more personal look, display diplomas, family pictures, awards, newspaper clips about your practice, etc. in your office and reception area.

Consider displaying the works of local artists in your reception area. Art displays give exposure to the artist and make your office more attractive.

Furnish your office with chairs instead of couches. Most people don't like to sit close to strangers when they're feeling well — much less when they're sick.

Help to create a pleasant and relaxing atmosphere with soft and relaxing music. Fresh flowers, refreshments (especially on a very hot or cold day) and holiday decorations can also help put patients at ease and make the wait a little easier.

If you frequently have children in your waiting area, design a children's corner with games, puzzles, coloring books, etc. to keep them busy and out from under the feet of your older patients.

Furnish your office with reading materials that are of interest to the patients you see — not just those which you like to read.

Make sure your examining rooms are neat, clean, bright and cheerful.

If patients have to wait in examining areas, furnish magazines, brochures or other reading materials to help them

pass the time. Above all, assure these patients privacy. Don't ask a patient to undress and then walk off with the door wide open to consult with a staff member or another patient.

Make sure the temperature of your examining room is comfortable to those who are undressed.

Make sure health information related to your practice is available in your office, waiting room and examining room.

Involving Your Staff

The way your staff members interact with your patients can be just as crucial to your success as your own communications with them. The following tips are designed to help your staff members become a successful part of your marketing effort.

Set a good example for staff members by behaving toward patients as you would like to have them behave.

Hire new staff members on the basis of attitude and friendliness toward other people, as well as their professional skills.

Hold regular staff meetings to discuss patient relations and to involve all staff members in your marketing objectives.

Discuss problems (rudeness with patients, etc.) with staff members and give them the opportunity to correct their behavior before issuing a formal warning or considering dismissal.

Compliment staff members who perform well with a kind note, a pat on the back or a simple "good

job."

Implement a program to reward staff members for special projects or objectives completed, such as a day off or a cash bonus.

If you find evening and Saturday hours are a necessity, allow staff to take time-off during the week for shopping or personal time — hire part-time workers to fill the gaps.

Take advantage of flex-time and staggered lunch hours to cover early morning hours or evening appointments. Some staff may prefer a 7 a.m. to 3 p.m. shift which will take care of patients who like to come in before work. Others may like to work from 12 noon to 8 p.m. Or alternate hours each day to cover patients and make staff happy.

Physician-Patient Communications

Talk to your patients. Allow enough time in your schedule to fully explain procedures, diagnoses, conditions, the need for lab tests, etc.

Always address patients by name. Ask if they prefer being called by their first name or surname.

Listen to your patients. Encourage them to ask questions and to discuss with you not only health-care problems but problems with your hours, waiting room, etc.

Keep up-to-date on patients' family life and personal accomplishments. Clip articles from the local newspaper about your patients and place them in their files, so that you can

comment on these items the next time they come in.

Allow 15 extra minutes for new patients — not just to fill out patient information sheets, but also to show them around the office, introduce them to your staff and explain your policies and procedures.

Give patients folders with your practice name and logo for them to retain records, appointments, health information sheets, brochures, etc.

Give patients small gifts letting them know how much you value their patronage. These can include T-shirts with the office logo, carrying bags, medical travel kits, first-aid kits, etc.

Give small gifts or coupons to those who have to wait more than 15 minutes to see you.

Compliment your patients on their efforts to lose weight, stop smoking, etc. On the other hand, do not criticize patients who are unable to do so.

Allow patients the dignity of being fully dressed when you discuss their health-care problems and answer their questions.

Take time to walk patients to the reception area or the door. Many office layouts can be very confusing.

Adding Some Personal Touches

Offer to make housecalls for very sick or elderly patients who cannot come in to see you.

Have staff offer to help patients with their insurance forms, particularly if they have repeated problems with them.

Give patients both written and verbal guidelines on how to use the medications you prescribe for them. Help them coordinate these with other medications they might be taking.

Start an office library with books, pamphlets, brochures and other materials related to your specialty and circulate these among your patients.

Pass out brochures about local

PHYSICIAN'S MARKETING HANDBOOK



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attractions, travel, entertainment, etc. — especially if many of your patients come from out of town in order to take advantage of your specialty.

Offer evening and weekend appointments for working patients or those whose schedules make it difficult to see you during the daytime. If this is not possible, set aside the first and last appointments of the day for these patients.

Sponsor wellness programs and seminars on stress management, weight loss, first aid, family planning, no smoking, etc. for your patients.

Scheduling for Effectiveness

Don't let your staff overbook your schedule.

Verify appointments on the phone that day and rearrange your schedule if you have a number of cancellations.

Acknowledge any delays immediately — if possible, by phone, prior to the patient coming into the office.

Set aside time each day for new patients, walk-ins or emergencies so that these things do not disrupt your schedule.

If you are located close to a shopping area and the wait to see you is generally long, provide your patients with beepers so they can leave and go shopping nearby.

OSMA

This series will continue next month with Treating Your Practice — III.

AIDS

Recommendations for Preventing Transmission of Infection with HIV/Lymphadenopathy-Associated Virus During Invasive Procedures

Background

On November 15, 1985, "Recommendations for Preventing Transmission of Infection with HIV/Lymphadenopathy-Associated Virus in the Workplace" was published.¹ That document gave particular emphasis to health-care settings and indicated that formulation of further specific recommendations for preventing HIV/lymphadenopathy-associated virus (HIV/LAV) transmission applicable to health-care workers (HCWs) who perform invasive procedures was in progress.

Toward that end, a two-day meeting was held at CDC to discuss draft recommendations applicable to individuals who perform or assist in invasive procedures. Following the meeting, revised draft recommendations for HCWs who have contact with tissues or mucous membranes while performing or assisting in operative, obstetric, or dental invasive procedures were sent to participants for comment. In addition, 10 physicians with

expertise in infectious diseases and the epidemiology of HIV/LAV infection were consulted to determine whether they felt additional measures or precautions beyond those recommended below were indicated. These 10 experts did not feel that additional recommendations or precautions were indicated.

Definitions

In this document, an operative procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices. An obstetric procedure is defined as a vaginal or cesarean delivery or other invasive obstetric procedure where bleeding may occur. A dental procedure is defined as the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, where bleeding occurs or the potential for bleeding exists.

Recommendations

There have been no reports of

HIV/LAV transmission from an HCW to a patient or from a patient to an HCW during operative, obstetric, or dental invasive procedures. Nevertheless, special emphasis should be placed on the following precautions to prevent transmission of bloodborne agents between all patients and all HCWs who perform or assist in invasive procedures.

1. All HCWs who perform or assist in operative, obstetric, or dental invasive procedures must be educated regarding the epidemiology, modes of transmission, and prevention of HIV/LAV infection and the need for routine use of appropriate barrier precautions during procedures and when handling instruments contaminated with blood after procedures.
2. All HCWs who perform or assist in invasive procedures must wear gloves when touching mucous membranes or nonintact skin of all patients and use other appropriate barrier precautions when indicated

continued on page 54



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200 mg sulfamethoxazole per 5 ml)



Please see summary of product information on following page.

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Before prescribing, please consult complete product information, a summary of which follows:

CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period, infants less than two months of age.

WARNINGS: **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.**

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS: *General:* Give with caution to patients with impaired renal or hepatic function, possible folate deficiency (e.g., elderly, chronic alcoholics, patients on anticonvulsants, with malabsorption syndrome, or in malnutrition states) and severe allergies or bronchial asthma. In glucose-6-phosphate dehydrogenase deficient individuals, hemolysis may occur, frequently dose-related.

Use in the Elderly: May be increased risk of severe adverse reactions in elderly, particularly with complicating conditions, e.g., impaired kidney and/or liver function, concomitant use of other drugs. Severe skin reactions, generalized bone marrow suppression (see WARNINGS and ADVERSE REACTIONS) or a specific decrease in platelets (with or without purpura) are most frequently reported severe adverse reactions in elderly. In those concurrently receiving certain diuretics, primarily thiazides, increased incidence of thrombocytopenia with purpura reported. Make appropriate dosage adjustments for patients with impaired kidney function (see DOSAGE AND ADMINISTRATION).

Use in the Treatment of Pneumocystis Carinii Pneumonitis in Patients with Acquired Immunodeficiency Syndrome (AIDS): Because of unique immune dysfunction, AIDS patients may not tolerate or respond to Bactrim in same manner as non-AIDS patients. Incidence of side effects, particularly rash, fever, leukopenia, with Bactrim in AIDS patients treated for *Pneumocystis carinii* pneumonitis reported to be greatly increased compared with incidence normally associated with Bactrim in non-AIDS patients.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently, if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffe alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: *Carcinogenesis:* Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination, concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folate acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).**

Hematologic: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. *Periarthritis nodosa and systemic lupus erythematosus* have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Ouresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: Usual adult dosage for urinary tract infections is one OS tablet, two tablets or four teaspoonfuls (20 ml) b.i.d. for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. Recommended dosage for children with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one OS tablet, two tablets or four teasp (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

HOW SUPPLIED: DS (double strength) Tablets (160 mg trimethoprim and 800 mg sulfamethoxazole)—bottles of 100, 250 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. Tablets (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. Pediatric Suspension (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). Suspension (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

STORE TABLETS AT 15°-30°C (59°-86°F) IN A DRY PLACE PROTECTED FROM LIGHT. STORE SUSPENSIONS AT 15°-30°C (59°-86°F) PROTECTED FROM LIGHT.

P I 0586



Roche Laboratories
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AIDS guidelines . . . cont.

(e.g., masks, eye coverings and gowns, if aerosolization or splashes are likely to occur). In the dental setting, as in the operative and obstetric setting, gloves must be worn for touching all mucous membranes and changed between all patient contacts. If a glove is torn or a needlestick or other injury occurs, the glove must be changed as promptly as safety permits and the needle or instrument removed from the sterile field.

- All HCWs who perform or assist in vaginal or cesarean deliveries must use appropriate barrier precautions (e.g., gloves and gowns) when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin. Recommendations for assisting in the prevention of perinatal transmission of HIV/LAV have been published.²
- All HCWs who perform or assist in invasive procedures must use extraordinary care to prevent injuries to hands caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments following procedures. After use, disposable syringes and needles, scalpel blades, and other sharp items must be placed in puncture-resistant containers for disposal. To prevent needlestick injuries, needles should not be recapped; purposefully bent or broken; removed from disposable syringes; or otherwise manipulated by hand. No data are currently available from controlled studies examining the effect, if any, of the use of needle-cutting devices on the incidence of needlestick injuries.
- If an incident occurs during an invasive procedure that results in

exposure of a patient to the blood of an HCW, the patient should be informed of the incident, and previous recommendations for management of such exposures¹ should be followed.

6. No HCW who has exudative lesions or weeping dermatitis should perform or assist in invasive procedures or other direct patient-care activities or handle equipment used for patient care.
7. All HCWs with evidence of any illness that may compromise their ability to adequately and sagely perform invasive procedures should be evaluated medically to determine whether they are physically and mentally competent to perform invasive procedures.
8. Routine serologic testing for evidence of HIV/LAV infection is not necessary for HCWs who perform or assist in invasive procedures or for patients undergoing invasive procedures, since the risk of transmission in this setting is so low. Results of such routine testing would not practically supplement the precautions recommended above in further reducing the negligible risk of transmission during operative, obstetric, or dental invasive procedures. Previous recommendations^(1,3,4) should be consulted for:

(1) preventing transmission of HIV/LAV infection from HCWs to patients and patients to HCWs in health-care settings other than those described in this document; (2) preventing transmission from patient to patient; (3) sterilizing, disinfecting, housekeeping and disposing of waste; and (4) managing parenteral and mucous-membrane exposures of HCWs and patients. Previously recommended precautions¹ are also applicable to HCWs performing or assisting in invasive procedures.

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References

1. CDC. Recommendations for preventing transmission of infection with HIV/lymphadenopathy-associated virus in the workplace. MMWR 1985;34:682-6, 691-5.
2. CDC. Recommendations for assisting in the prevention of perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus and acquired immunodeficiency syndrome. MMWR 1985;34:721-6, 731-2.
3. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
4. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.



Preventable Trauma Deaths

By Kenneth A. Kudsk, MD and Patrick M. Fardal, MD

A clinical and autopsy study was undertaken of severely injured trauma victims transported by Columbus EMS in 1983-84. A panel of physicians determined the rate of preventable deaths in patients arriving at hospitals alive but subsequently dying. The results demonstrate that an

unacceptable preventable death rate occurs in the Columbus system of delivery to the closest hospital. These results are consistent with all previous studies of non-regionalized trauma care for severely injured trauma patients.

Over 150,000 people die each year as a result of trauma. Trauma strikes the youngest, most productive members of society inflicting an extremely high price on society. Despite these costs, trauma issues have not enjoyed the same national attention as cancer or heart disease.

Because of the medical and economic implications of this problem, a trend toward regionalized emergency care of the critically injured is developing. Two conclusions are obvious from the 30 papers published to date on this issue: 1) unacceptably high

preventable death rates occur in EMS systems that take patients to the closest hospital and 2) delivery to the most appropriate hospital minimizes the problem.¹ Proponents of the concept point out that regionalization provides appropriate resources for the critically injured and avoids expensive duplication of services. Opponents cite the high economic and political costs of "changing the system" and often contend that "preventable deaths don't occur" in their community.

In early 1985, the office of the Safety Director of the City of Columbus requested a study of

trauma-associated deaths for 1983-84 to determine preventable death rates. The Columbus metropolitan area, with a total population of 867,000, is composed of the city of Columbus and 27 townships. Each of these townships as well as the city provide their own EMS service. Columbus EMS serves approximately 50% of the total metropolitan population. Only patients transported by city of Columbus EMS squads were included in the study. The hospital charts were requested for review and the coroner's office provided autopsy reports. That study serves

as the basis for this report.

Materials and Methods

A combined clinical and autopsy audit was carried out by a panel consisting of a trauma surgeon, a forensic pathologist in the coroner's office, and an emergency department physician. The techniques for such studies have been amply described by West.² Deaths upon arrival and central nervous system (CNS) deaths were eliminated from review. Since clinical records were provided, CNS deaths might have been audited, but the panel agreed that judging the salvageability of head-injured patients was difficult at best, and if they were included, the study's credibility might be impaired. Coroner's records and police reports were reviewed, and charts of patients were requested from the hospitals if there were signs of inadequate or inappropriate care while in the hospitals. These signs included deaths in patients younger than 50 years of age, deaths occurring less than six hours after arrival at a hospital (except for patients with injury to the heart or great vessels with rapid decompensation), failure to perform an exploratory laparotomy or thoracotomy for bleeding, and hemorrhagic deaths.² Motor vehicle accidents were closely scrutinized. Covert, life-threatening injuries such as pericardial tamponade, tension pneumothorax, etc. are often masked by more obvious visible injuries. These covert injuries result in the majority of preventable deaths in most series. Penetrating injuries are uncommonly found in studies since the site of injury gives obvious clues to the organs injured.

No analysis of prehospital care was undertaken. The question was simple: of people transported by Columbus EMS squads to hospitals alive who subsequently

died (not of head injury), how many died unnecessarily? By determining the preventable death rate in this way, the magnitude of preventable deaths in the entire system (prehospital and in-hospital) was not determined. The study defined the frequency of inadequate or inappropriate care in a small, well-defined group of seriously injured patients who arrived alive at the hospitals in a non-regionalized system of patient delivery.

Results

Two-hundred and fifty-four patients who were transported by city of Columbus EMS died from trauma in 1983-84. There were 128 penetrating and 123 blunt trauma victims. The 203 patients found dead at the scene or who died in transport were excluded from further study. (Table I)

Of the remaining 51 cases for review, two charts were missing and no autopsy was performed on a third (Table I). Twenty-four additional patients died of head injuries soon after admission, in the operating room, or in the ICU at a later time. Seven additional patients with severe, irreversible head injuries became organ donors. One death was unrelated

to trauma. The 16 remaining patients arrived at the hospital alive but died of non-CNS causes and served as the study population.

Ten sustained penetrating wounds, and six blunt injury. Of these 16, three were clearly not preventable deaths. Medical care was provided in a competent, timely fashion, but the magnitude of injuries precluded survival.

The panel concluded that nine of the 16 study patients died unnecessarily (Table II) as a direct result of poor medical and surgical care. Excessive delays in the emergency room despite definite surgical indications, inadequate resuscitation, missed injuries, iatrogenic deaths, and/or poor surgical judgment were cited in all cases.

The final four patients in the study group generated discussion among the panelists and were deemed potentially preventable. These patients spent excessive time in the emergency departments prior to diagnostic studies or surgery and several were hemodynamically unstable and poorly resuscitated. It was unclear whether the injuries sustained would have been fatal although injuries were probably not lethal in two of the patients. Panelists agreed that inadequate resuscitation and excessive delays aggravated the condition of all four patients.

Of the patients who arrived alive at hospitals and subsequently died

Table I
254 Trauma Deaths 1983-84

Missing charts	2
No autopsy	1
Remaining cases for review	251

Cause of Injury	Penetrating (128)	Blunt (123)
DOS/DOA	111	92
Died in ER (Head)	—	3
Died in OR (Head/Aorta)	1	2
Donor	3	4
Delayed deaths	3*	15**
Death not trauma-related	—	1
Study patients	10	6

*All gunshot wounds (GSW) to head (deaths 8 hrs — 4 days)

**All had head injuries. No review; however at least two had delay or possibly overlooked diagnoses.

of non-CNS injuries, nine of 16 (56%) sustained preventable deaths. Three of 16 (18%) were clearly not preventable. The remaining four could not clearly be included in either group.

Discussion

One of the first reports which drew attention to inadequate trauma care came from Columbus, Ohio in 1953.³ That study quantitated mortality and morbidity rates in 794 traffic

injury victims cared for at a local hospital and pinpointed three areas in which physicians were accountable to improve trauma care: 1) the provision of competent prehospital care; 2) the training of physicians in trauma management; and 3) the promotion of measures that prevent trauma or ameliorate injuries. The present study, applying more current audit methods, is the second from this community.

Each year, over 150,000 people

die as a result of trauma, and unfortunately, many victims could have been saved had their accident occurred in a system of regionalized trauma care. At least 20 studies document that inappropriate, uncoordinated trauma care results in unnecessary deaths.¹ When triage is determined by EMS squad personnel on the basis of proximity of the hospital rather than suitability, an unacceptably high rate of preventable death and disability occurs. Our study is consistent with those results. Conversely, virtually all studies investigating the effect of regionalized trauma care on mortality and morbidity following severe injury have shown an improvement in patient survival and a decrease in the incidence of preventable deaths.¹

The present study does not define the total number of patients sustaining preventable morbidity and mortality. It measures only lethal failures — and then only a select group of in-hospital lethal failures. During the study period, only one Level I institution verified by the American College of Surgeons review existed in Columbus. At the request of that institution, this trauma study originated under the auspices of the EMS Advisory Council, a body comprised of emergency department physicians from each of the Franklin County hospital systems, despite opposition from members who stated that “there are no preventable deaths in Columbus.” To ensure that the concept of preventable deaths was clear, strict criteria were adopted, which eliminated prehospital deaths and all central nervous system deaths. Almost certainly there were additional preventable deaths which were not delineated. In Ramenofsky’s study of pediatric patients, almost 50% of patients who died before they reached the hospital could have been salvaged

continued on page 60

Table II
Preventable Deaths

Scenario	Reason for Preventable Death
1. 52-y-o GSW to abdomen	a) Excessive delay in ER. b) No airway protection. c) Aspirated blood 75 min after arrival; Died 45 min later in ER. d) No lethal injuries at autopsy.
2. 31-y-o MVA	Missed pericardial tamponade with no attempts at pericardiocentesis or open thoracotomy.
3. 76-y-o MVA	Esophageal intubation caused cardiac arrest.
4. 57-y-o MVA	a) Developed drowsiness in ICU; delays in 1) diagnosis, 2) performing CT scan, 3) neurosurgical intervention for subdural hematoma.
5. 30-y-o GSW to r lower chest and abdomen	a) 2-hr delay in ER with inadequate resuscitation (50-80 mm Hg over two hours) b) Isolated lesion to right lobe of liver, nonlethal.
6. 22-y-o stabbed in abdomen. Control of vena cava and small bowel injuries at in- ital op. Taken to ICU.	a) Treated post-op hypotension due to intraabdominal hemorrhage with pressor agents; 2½ L of blood found in abdomen at autopsy. b) Missed small bowel injuries. No lethal injuries. c) Died due to unresuscitated, uncontrolled shock.
7. 29-y-o GSW to abdomen	a) Died ½ hr postop in ICU from tension hemothorax due to malposition of right jugular vein catheter into right pleural space. No chest X-ray in ER or ICU following line placement. b) Nonlethal injuries
8. 26-y-o GSW to left chest, lodg- ing in right chest.	a) Aortogram performed two hours after admission to ward bed following emesis of bright red blood. b) Decompressed mediastinal hematoma in stable patient before gaining control of aorta. Patient promptly exsanguinated.
9. 29-y-o GSW to abdomen	a) Delay in ER of over one hour despite continued need for vigorous resuscitation. b) Coagulopathy developed.

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1594H7



BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

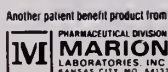
While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

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References:

1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P: *Am J Med* 79(suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987.



1594H7

Preventable Trauma Deaths . . . continued

Table III
Potentially Preventable Deaths

Scenario	Reason for Decision
1. 18 y-o- MVA	100-minute delay in ER in unstable patient with obvious intraabdominal injury. Torn left iliac vein and fractured pelvis found.
2. 30-y-o MVA	Two-hour delay in ER despite obvious intraabdominal bleeding. Macerated spleen and nonbleeding liver injury found. Inadequate resuscitation.
3. 24-y-o MVA	Unnecessary delay in performing aortogram (no injury) then another delay before going to OR. Intraabdominal injuries controlled, but died of multiple organ failure.
4. 32-y-o GSW to lower abdomen	Delay in ER despite intraabdominal hemorrhage from injured iliac artery and vein. Arrested in ER after poor resuscitation.

had there not been field treatment errors, transport errors and definitive care errors.⁴ Others have shown that over 25% of deaths due to CNS injuries are preventable.⁵ None of these populations were included in the current study.

The study is particularly compelling when considering the number of preventable deaths due to penetrating trauma. To have patients expire from covert injuries following severe blunt trauma is somewhat understandable. Diffuse injuries to the torso, head and extremities producing airway compromise, hypotension and bleeding can be difficult to interpret — hence the need for fewer physicians caring for a high volume of these patients in fewer trauma centers. To have patients die in an emergency room, poorly resuscitated, with a gunshot wound to the abdomen without attempts at surgical control is unconscionable! In most series penetrating trauma is a small if nonexistent population since the site of the wound points to the area of pathology. Six of the nine preventable deaths in this study were due to penetrating trauma.

The problem is not with any single hospital or single group of hospitals. This study should be construed as a severe criticism of

the existing patient delivery system in Columbus, Ohio. Maintaining advanced trauma care is expensive. It requires 24-hour-availability of expensive resources such as CT scanners, angiography, blood banking and the people to run them. Surgeons must be immediately available to provide surgical expertise to critically injured patients if they are to survive. Physicians require repeated, frequent exposure to the life-threatening problems to assure expertise in their diagnosis and management. Delivery of the relatively few patients to a large number of institutions dilutes experience for all. The answer is not trauma center proliferation as has subsequently occurred in the community.

Unfortunately, no legislative body in Ohio assumes authority to determine the number of trauma centers necessary and designate them. At present, the responsibility rests upon the shoulders of physicians. One method would be to develop a quality assurance program for all severely injured patients. Cases resulting in significant morbidity (amputations, paralysis, etc.) as well as morbidity must be scrutinized. Confidentiality is important but all institutions accepting these critically ill patients should



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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS.)

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.

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Revised, April 1982.

5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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comply. Independent agencies of experienced trauma professionals could generate the review. Public agencies with power to determine delivery protocol must insist on hospital involvement as a prerequisite to delivery of the severely injured to that institution. Unless driven by physicians, change benefiting severely injured patients will not occur.

Summary

This study confirms the conclusion of all similar studies published to date: a high death rate occurs in a system where patients are delivered to the closest hospital. The excessive rate of preventable deaths following penetrating trauma is exceptional testimony to the shortcomings of the existing system. Current studies demonstrate that regionalized care which concentrates care and reduces unnecessary duplication of expensive resources can eliminate this problem. The answer is not to proliferate trauma centers. Trauma registries, continual critical review of outcome and education of the public are needed. **OSMA**

REFERENCES

1. Cales RH, Trunkey DD: Preventable trauma deaths. A review of trauma care systems development. *JAMA* 1985; 254:1059-1063.
2. West JG, Cales RH: Methods of evaluation of trauma care. In West JG (Ed): *Trauma Care Systems: Clinical, Financial and Political Considerations*. New York, Praeger Scientific Publ, 1983:141-151.
3. Zollinger RW: Traffic injuries: A surgical problem. *Arch Surg* 1955; 70:694-700.
4. Ramenofsky MC, Luteran A, Quindlon E, et al.: Maximum survival in pediatric trauma: The ideal system. *J Trauma* 1984; 24:818-823.
5. West JG, Trunkey DD, Lim RC: Systems of trauma care: A study of two counties. *Arch Surg* 1979; 114:455-460.

Kenneth A. Kudsk, MD,
Columbus, is assistant professor of surgery at Ohio State University's College of Medicine. **Patrick M. Fardal, MD,** also from Columbus, is Chief Forensic Pathologist, Franklin County Coroner's Office.

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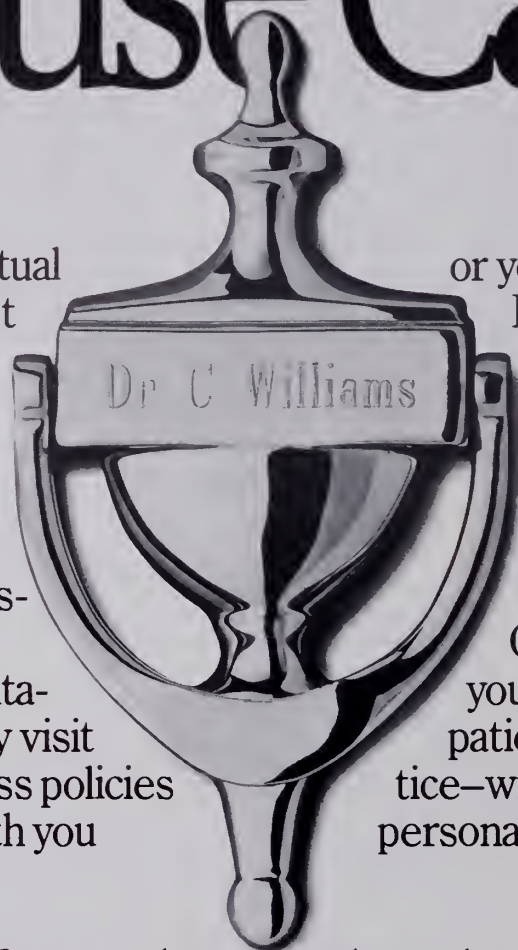
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Waging a War Against Cholesterol

By Deborah Athy

By now you have probably heard the news. The National Heart, Lung and Blood Institute is asking physicians nationwide to aim for lower blood cholesterol levels in their patients. The overall goal is to reduce the number of heart attacks in the country.

If physicians heed this message, an estimated 25% of adult Americans will be placed on cholesterol-lowering diets or medication therapy, according to some reports.

Cholesterol — along with its sidekicks, hypertension and cigarette smoking — has previously been associated with an increased risk of heart disease in other studies and reports. So what's new about the National Cholesterol Education Program's recommendations?

The October 1987 report on the Detection, Evaluation and Treatment of High Blood Cholesterol in Adults is considered the first physician guide that provides step-by-step instructions for identifying high-risk patients and gives recommendations for

detection, treatment and monitoring of blood cholesterol levels.

What's more, rather than categorizing cholesterol levels by age and sex, the report provides uniform levels for men and women of all ages — although male sex is considered a "risk factor" for coronary heart disease (CHD).

Additional risk factors include: a family history of CHD, cigarette smoking, hypertension, obesity, low HDL-cholesterol concentration, diabetes mellitus, and a history of vascular disease or strokes.

A key number emerging from the report is a national goal of 200 milligrams per deciliter (mg/dl) of blood serum as a desirable blood cholesterol level. This goal "came out of studies where cardiovascular risk increased significantly with blood cholesterol levels above 200 mg/dl," explains Edward Bope, MD, president of the Central Ohio Academy of Family Physicians.

The 22-member panel of national blood cholesterol experts recommend that cholesterol levels in adults should be 200 mg/dl or

lower. Patients who meet these desirable levels should be given general diet guidelines and be retested every five years or during physical exams.

Other guideline levels outlined in the report:

- 200-239 mg/dl is considered borderline-high blood cholesterol. Repeat test to confirm result. Institute dietary changes and repeat test annually.
- 200-239 mg/dl with two risk factors or 240 mg/dl and higher is considered high blood cholesterol. The report recommends implementing an intensive treatment program, including changes in diet and possible drug therapy. A lipoprotein analysis to measure total cholesterol, total triglycerides and HDL-cholesterol is also recommended.

Physicians have recognized for some time that cholesterol levels have been linked to cardiovascular risk. But as Columbus endocrinologist Charles M. Katz, MD, points out, "Once you accept the fact that cholesterol is an important risk factor in cardiovascular incidents, and I do,

The new guidelines have already made an impact, prompting people to ask, "What is my cholesterol level and how does it compare to the guidelines?"

it is important to establish limits."

Some members of the panel suggested that borderline high-blood cholesterol with one risk factor also warrants a lipoprotein analysis, although this is not a general recommendation in the report.

"The level of LDL-cholesterol will serve as the key index for clinical decision-making about cholesterol-lowering therapy," according to the report. General guidelines for LDL-cholesterol include: levels less than 130 mg/dl, desirable; 130-159, borderline high-risk; and 160 mg/dl or above, high-risk.

The cholesterol experts also recommend that all adults age 20 and above should have their blood cholesterol levels tested and be evaluated for the presence of additional risk factors. According to a recent survey, almost 90% of Americans are unaware of their blood cholesterol status. (Although this report focuses on adults, a future panel plans to look at blood cholesterol in children and adolescents.)

These new guidelines have already made an impact by prompting people to ask, "What is my cholesterol level and how does it compare to the national guidelines," says Dr. Bope. Enhanced awareness among the public is important because individuals often direct their own health care and may take this opportunity to come in to the doctor's office to be tested, he says.

"In my own practice cholesterol levels are done as a part of the

regular exam. But these levels are now more reportable to patients, who are more knowledgeable and interested in their cholesterol levels."

Dr. Katz agrees. "Patients are more interested and are asking more questions. Whenever patients take an interest in their own health it's a positive outcome — except when they get *distorted* views, and then it's an interference."

Not only has the report captured the public's attention, but it has also spurred action in the medical community. A good thing, considering that a recent survey found that many physicians are lax about battling cholesterol. Only 50% reportedly recommended diet therapy for their patients with blood cholesterol levels of 240 mg/dl and above.

An estimated 40 million Americans between the ages of 20 and 74 currently reside in the "danger zone" of high blood cholesterol levels. If the above survey is representative, half of these individuals were being left untreated.

Many experts believe this report will do as much for cholesterol awareness as a 1972 report on acceptable levels of blood pressure did for hypertension.

In a recent article, panel member Dewitt S. Goodman, MD, said, "We (the panel) think medical practice will undergo a major change on the basis of this report and other educational efforts."

"Physicians are getting much more aggressive and are paying more attention to what we used to

call 'borderline' blood cholesterol levels," Dr. Katz agrees. "We are emphasizing diet to more patients and initiating drug therapy at lower levels."

While Drs. Katz and Bope perceive 200 mg/dl as a reasonable "goal," they emphasize it's not a carved-in-stone requirement. "The 200 mg/dl guideline is a reasonable level for most young adults, but we often have to allow some flexibility for older adults, especially those with medical illnesses," Dr. Katz explains.

At Riverside Hospital, where Dr. Bope is the director of Family Practice residency, sometimes a level above 200 mg/dl is the best we can do, he says. "We have to look at the total blood picture and take various risk factors into account."

The cholesterol report also allows for blood cholesterol variability based on the patient and the judgment of the physician.

As a result of the new guidelines, individuals with higher than desirable blood cholesterol levels should be encouraged by their physicians and other health professionals to evaluate their diets for possible areas in which to cut fats and cholesterol. Most diets can be trimmed without radical changes, the report notes, by eliminating fatty cuts of beef and pork; cold cuts; bacon; whole and 2% milk; egg yolks; and high-fat cheeses, among other things.

High-fat items should be replaced with fish; poultry sans skin; low-fat milk, yogurt and cheeses; and egg whites.

Although dietary treatment is

the "cornerstone" of cholesterol-lowering therapy, Dr. Bope cautions those individuals who take this as an invitation to embark on severely restrictive diets. "Those individuals who are trying bizarre restrictive diets are really doing themselves a disservice in other areas," he says.

"The general aim of the dietary therapy is to reduce elevated cholesterol levels while maintaining nutritionally adequate eating patterns," according to the report. Initial diet recommendations include cutting fat to 30% of total calories, saturated fatty acids to less than 10%, and cholesterol to 300 mg per day.

If a low-fat diet does not reduce blood cholesterol levels over a six-month period, physicians may then want to consider medication therapy. Patients with LDL-cholesterol of 190 mg/dl or greater and those with LDL-cholesterol of 160-189 mg/dl who have CHD or

two other risk factors should be considered candidates for drug therapy, the guidelines suggest.

The cholesterol-lowering drugs of first choice among the national panel are bile acid sequestrants (cholestyramine and colestipol) and nicotinic acid, which have been shown to safely lower CHD risks in clinical trials. However, the panel notes that these drugs require significant patient education to be effective.

Lovastatin, the first of a new class of drugs (HMG CoA reductase inhibitors), has been found to be effective in lowering LDL-cholesterol, but long-term safety and the effect on CHD risks have not been established.

A variety of cholesterol-measuring drives have been kicked off in malls, clinics and health fairs in a number of U.S. cities since the release of the cholesterol program report. Patients who test above 200 mg/dl in a public

screening should contact a physician for further evaluation, the panel suggests. In addition, keep in mind that blood cholesterol levels can vary from day to day and from lab to lab.

A proverbial concern to the cholesterol-lowering program has been whether increased testing will elevate health-care costs. As Dr. Katz sums up, "The potential benefits of the program outweigh the costs of testing, especially if it means a decrease in the number of cardiovascular deaths."

To obtain a copy of the Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults, write: National Cholesterol Education Program; National Heart, Lung and Blood Institute; C-200; Bethesda, MD 20892; (301) 230-1340. **OSMA**

Deborah Athy is Associate Editor of OHIO Medicine.

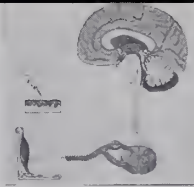
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- Assessing Impairment of Elderly Hospitalized Patients - Routine Radiological Testing for Respiratory Illness - Using Ultrasound to Detect Hip Abnormalities - Diagnosing Bone Infection Under Pressure Sores - Slowing Progression of Diabetic Nephropathy - Behavioral Disorders Among Children of Alcoholic Fathers - Catheter-Related Septic Central Venous Thrombosis	- Withdrawing Patients From Antihypertensive Drug Therapy - Cesarean Section and Infant Survival - Preventing Neonatal Group B Streptococcal Disease - Diagnosing Acute Serotail Pain Urinary Tract Infections Among Uncircumcised Infants - Colonoscopy: Detecting Recurrent Colorectal Cancer - Surgical Management of Chronic Intestinal Ischemia - Preventing Travelers' Diarrhea
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SPECIAL FEATURE

Willingway: A Fellowship in Alcoholism and Drug Addiction



Stark County's real-life "Quincy"

By Michelle J. Carlson

When skeletal remains were discovered last summer near a Canton steel plant, Stark County Coroner James R. Pritchard knew almost immediately the case was a little out of the ordinary.

"Bones show up occasionally," he says now, "but the vast majority of them are animal bones."

The skeleton, however, which was discovered near a truck entrance to LTV Steel by a night watchman, turned out to be that of a human female.

Since being elected county coroner in 1981, Dr. Pritchard has examined only one other human skeleton — one found in a field about five years ago. The difference between the two cases,

he says, is that trace evidence — namely clothing and jewelry — was found near the first skeleton, making it relatively easy to identify.

"In this case," Dr. Pritchard says, "we didn't have that, so we had no leads. We didn't have any other evidence at all. Nothing."

By carefully combing the area in which the skeleton was found, Dr.

“We actually do what Quincy does . . . It’s a combination of scientist, detective and physician.”

*James R. Pritchard, DO
Doctors Hospital*



Pritchard managed to collect all of the bones, the skull, and all but one of the teeth.

With the help of Dr. C. Owen Lovejoy, a forensic anthropologist at Kent State University, and dental surgeon Dr. Bernard Johnson, Dr. Pritchard was able to estimate that the skeleton was that of a black female, approximately 22 years of age and approximately 5'7" tall.

“By looking at the skeleton,” he explains, “you can tell the age, height, sex and race.” Also, he adds, “Because we had all of the teeth but one, that helped because they could tell she had an overbite . . . and her two front teeth were separated.”

Still, the coroner had no way of identifying the skeleton — until he sent the skull to forensic sculptor Stephen Hale, who works as an investigator in the Greene County Coroner’s Office.

Armed with information provided by Dr. Pritchard, Hale set about reconstructing a clay model of the skull using a process known as facial reconstruction.

During this process, clay is applied to the skull in varying thicknesses that approximate the characteristics of the skeleton’s race and sex. “I go through my data . . . and it’ll tell me a

particular measurement in millimeters,” explains Hale.

While sculpting the basic features is fairly scientific, the size and appearance of the nose, lips and ears are left to the sculptor’s discretion. “It’s scientific to the point that science has brought us to today,” Hale says, “. . . (but) you really do guess at the end.”

The clay model was subsequently returned to Dr. Pritchard and a photo of it published in local newspapers — prompting 17 people to call the coroner’s office and identify the woman as 25-year-old Denise DeGraffinreed of Canton.

“Once we found out who she was, we got the medical and dental records,” says Dr. Pritchard.

From those records, the coroner’s office was able to tell that the woman had had her lower left molar extracted — the same tooth that Dr. Pritchard was unable to locate when the skeleton was first found. It was also determined that she had six lumbar vertebrae instead of the normal five — so did the skeleton.

“Everyone’s a little bit different,” says Dr. Pritchard. “We were lucky we had a large number of X-rays to compare (the skeleton) to.”

With the skeleton finally

positively identified, two questions still remained: When and how did Denise DeGraffinreed die?

Last seen by family and friends in August 1984, she was never reported missing because she was an adult. “We felt she might have died in 1984, but we can’t pinpoint it at all,” says Dr. Pritchard.

Neither can the coroner’s office determine how she died, though Dr. Pritchard suspects it was a violent death, namely because of the trauma to the skeleton and because of the location of where it was found.

“This is a place where you wouldn’t go for a walk,” says Dr. Pritchard, explaining his suspicions. “It’s out in the middle of nowhere.”

While chances are good that no one will ever know exactly what happened to the young woman, Dr. Pritchard says work is still being conducted on the skeleton in the hopes that microscopic bits of metal or glass may be found embedded in the bones — indicating, perhaps, that a weapon was used.

While the case of the mystery skeleton may strike most people as odd, Dr. Pritchard appears unruffled.

“We really see a lot of different cases,” Dr. Pritchard says. “I’ve

"Every case we have is a little unusual. Every one has a twist . . ."

seen everything from poisonings to industrial accidents. And we continue to see it all."

He cites an instance in which a partially-decomposed arm was brought into his office by local police. While police were convinced the arm was that of a human, Dr. Pritchard was able to determine that it belonged to a bear. "What a bear is doing in Stark County, I don't know," he says. How the bear lost the arm remains a mystery as well.

Another case Dr. Pritchard was called on to investigate involved a man who appeared to have suffered a heart attack while

fishing. It was later discovered that while the man was holding up a fish, admiring his catch, the fish somehow wriggled loose and became lodged in the man's throat, causing him to suffocate.

"Every case we have is a little unusual," Dr. Pritchard says. "Every one has a twist."

Some cases require more than medical detective work: After Dr. Pritchard ruled a man's death a suicide, the man's widow challenged the decision, maintaining that there was no way her husband would have committed suicide. A little background digging by the

coroner's office, however, revealed that the man had been embezzling money from his company and was about to be prosecuted — something his widow had not been aware of.

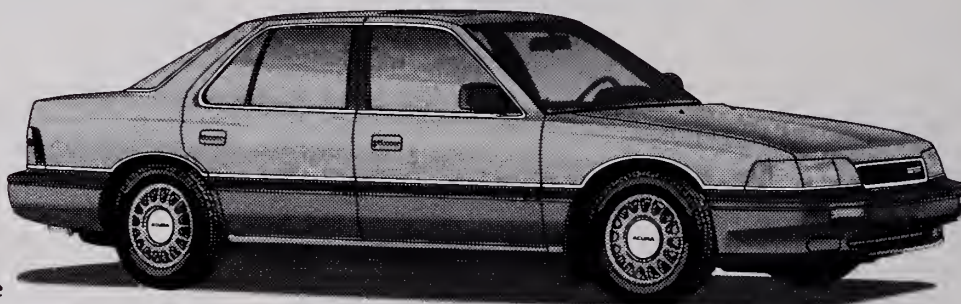
"We actually do what Quincy does. That is true," says Dr. Pritchard. "It's a combination of scientist, detective and physician."

It is also, as the saying goes, all in a day's work. **OSMA**

Michelle J. Carlson is Editorial Assistant for OHIO Medicine.

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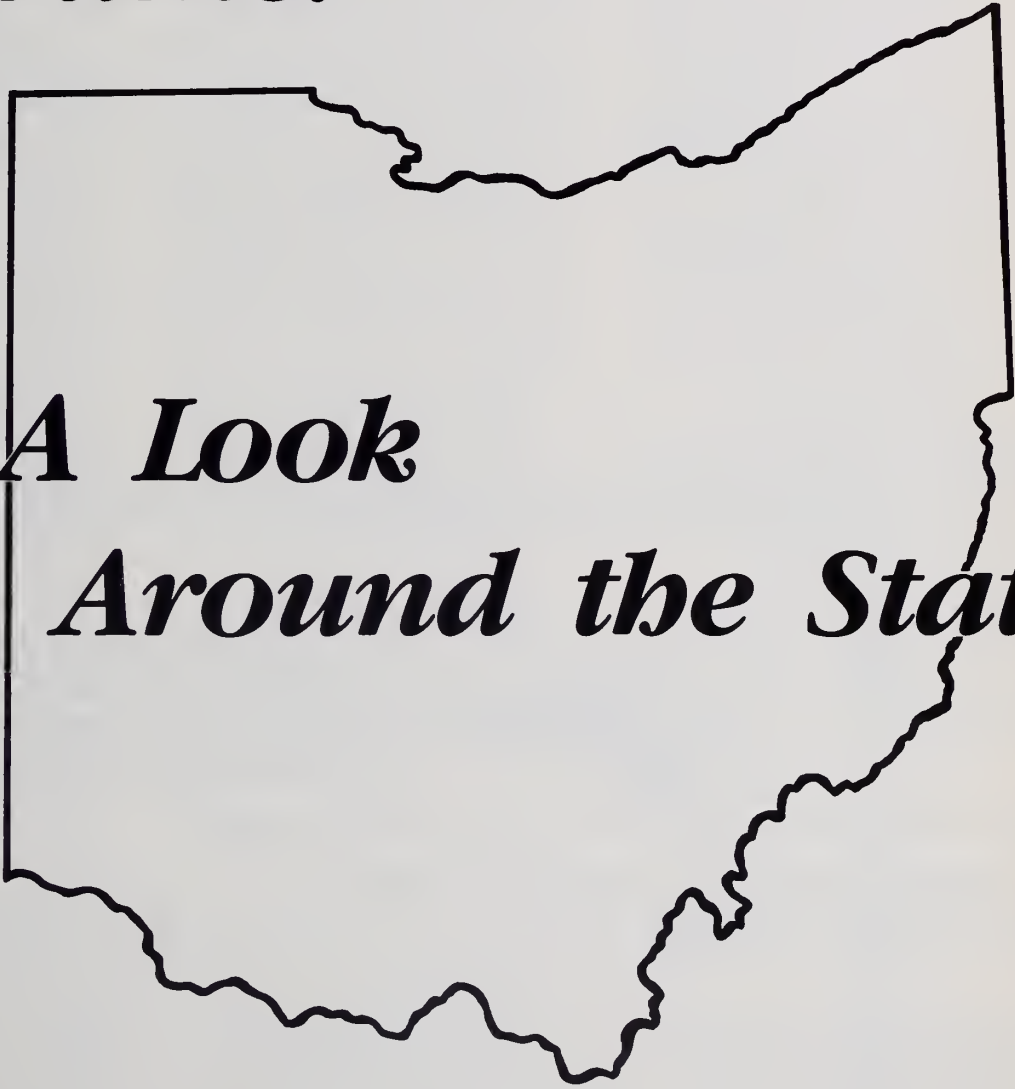
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Student Impairment Programs:



A Look Around the State

At the OSMA-MSS Annual Meeting in February of 1987, Resolution 8 was passed unanimously by the House of Delegates. Resolution 8 deals with surveying Ohio medical schools' existing impairment programs in order to define the scope of existing impairment programs and to establish a

working referral for schools that want to develop school-based student-run impairment programs. Resolution 8 was spurred by the growing number of medical students who are impaired and the lack of appropriate medical student impairment programs. The following are the results of the OSMA-MSS Medical School

Impairment Survey.

All schools which returned a completed survey teach courses about behavioral and psychological aspects of impairment during the first year and physiopharmacological aspects during the second year. In addition to regular course work, Wright State University (WSU) has a

Weekend Intervention Program, the University of Cincinnati (UC) offers two hours specifically addressing impaired physicians, and both Northeastern Ohio Universities College of Medicine (NEOUCOM) and Ohio State University's College of Medicine (OSU) offer small group sessions with recovering physicians.

All schools reported having primary preventative measures of an educational nature. Besides education, WSU and NEOUCOM have support groups. All schools are open to and welcome association with other groups concerned with impairment.

Due to the inherent difficulty in obtaining confidential responses from students with respect to the percentage of those impaired, none of the schools surveyed were confident in their ability to identify the percentage of students who were impaired either via alcohol, chemical substance and/or psychological problems.

All schools surveyed have school-based referral programs. These programs primarily utilize student health and counseling services within the university or hospital-affiliated system.

existing and proven effective methodologies utilized by the Phoenix Society at Louisiana State University and Aid to the Impaired Medical Student at the University of Tennessee at Memphis.

Normally students go to their peers and trusted faculty identified during freshman orientation for counseling purposes when they have a problem. All schools report encouraging students who know of colleagues who are impaired to seek help.

The following quote from Hutch Williams, MD, Associate Dean for Student Affairs at OSU sums up the feelings of the individuals surveyed concerning the affiliation of treatment providers to the school.

"The relationship of treatment providers for the most part is informal, both as to the school itself and to the administrators even when those individuals are members of the faculty, particularly in the Department of Psychiatry. Since it is often difficult to convince the students that making a problem known to someone in the administrative

accusing student is willing to come forward which they claim is in accordance with the United States Constitution. No school offered guidelines for handling malicious reporting. James Boex, Associate Dean of Student Affairs at NEOUCOM, feels this issue should be addressed by the Student Conduct Council.

Case files are reportedly only accessible to the committee members dealing with impairment at UC. At the other schools, files are kept by the individual therapists.

With respect to treatment refusal, all but the University of Cincinnati require individuals to be reviewed by the Dean of the College with possible dismissal.

At UC since treatment is voluntary, treatment refusal was not discussed. In order to confirm that a student is receiving treatment outside the school setting, all schools suggest release of information from the therapist with the student's permission.

The only school reportedly offering more than one relapse before dismissal was OSU. Procedures for follow-up were not specifically detailed by the responding schools.

Psychological impairment is viewed differently at each of the schools. The University of Cincinnati is reportedly very concerned about psychological impairment and responds by offering frequent announcements about available programs. At OSU, psychological impairment is handled as though the students were a physician in practice. At NEOUCOM, psychological impairment is seen as an impediment to graduate. Wright State University reported that approximately one half of the students seek counseling about a psychological problem at some point. Psychological impairment is treated by psychiatrists and psychologists in student health services, faculty members and

The schools were not able to give the percentage of students impaired via alcohol, drugs or psychological problems.

NEOUCOM refers their students to treatment facilities like Glenbeigh when students need services not offered by the school. The University of Cincinnati is the only responding school which attempts to rehabilitate students and residents through a school-based impairment program. Ohio State University's College of Medicine and NEOUCOM are currently developing student-run impairment programs. These programs are based upon already

capacity will not become a part of their official record, the availability of external sources is important and is encouraged."

When asked how schools investigate a student's allegations about another student's impairment without confidentiality being lost, all schools acknowledged the sensitivity of this issue. The University of Cincinnati states that no investigation will occur unless the

outside practitioners.

Jep Hostettler, PhD, from OSU, sums the general feelings of the responding schools when he says, "Mandatory drug testing is an impingement on students' rights. However, if there is due cause and justifiable reason, drug testing could be mandatory for certain students."

In summarizing the responses, it is clear that the four responding schools are deeply concerned with the present status of medical student impairment and are taking steps toward improving the management of impairment. Each of the schools report an adequate substance abuse education with the availability of additional programs. The questions presented in this survey reflect the authors' concerns about topics that need to be addressed when reviewing the

effectiveness of a school's approach to medical student impairment. Issues that need to be considered in any impairment program, which were not answered by this survey include:

- Establishing a centralized, trusted group of individuals to whom students can go to with concerns about themselves or colleagues
- Confidentiality throughout the process
- Availability of inpatient treatment
- Monetary support for those students who do not have the resources
- How reentry is handled
- What happens to the files upon graduation? Do you inform residency directors? Destroy the files upon graduation? Notify the state impaired physicians

program? Not allow graduation until treatment has been successfully completed?

The OSMA-MSS would like to thank the editors of *OHIO Medicine* and the members of the OSMA's Physician Effectiveness Program for their continuing support. For individuals desiring more information on student-run impairment programs, please contact:

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1467 Runaway Bay Dr. #3B
Columbus, OH 43204

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Perspectives & Reminiscences

By Eduard Eichner, MD

My postgraduate training started before THE crash. In my senior year at school, I spent several months as a "surgical pup," the equivalent of a surgical scrub nurse. I selected the instruments for each case, saw these were properly sterilized, set up the operating table and assisted as a nurse. After the operation, I cleansed all the instruments, and put them away again until needed. For salary, I got room and board; whites, or uniforms; and certain fringe benefits, but no cash. The surgeon's preoperative scrub and mine at that time was a prolonged green soap wash with a brush, followed by the "wet glove technique." The gloves then were more like current kitchen gloves in thickness and lack of sensation — so much so that some surgeons still operated without gloves. The gloves, when used, were soaking in a weak solution of bichloride of mercury. We soaked our hands and arms in this solution, and then put on the gloves, rinsing before picking up the scalpel. The mercury probably prevented possible leptic infections, although this was never presented or discussed. We now know that

mercury can also be a good fungicide.

The following year was spent as a rotating intern at \$25 a month, with the previously mentioned benefits. The stock market broke in the fall of '29, and we occasionally admitted, treated and even operated and discharged a patient without the visitant ever being present. There was no malpractice then. Many staff physicians were often more involved with their brokers than with patient care. During that year I saw suicides committed by previously wealthy men who hoped that double disability and accidental death policies would better support their families than each thought he could do in the future. Occasionally there was comic aspect to these tragedies, which I will not record. Today, many of these tragedies are associated with drug-induced depressions. Regarding drugs — we had our share of addicts, as many working women received morphine for treatment of severe dysmenorrhea. Today, non-addictive anti-prostaglandins give remarkable relief with minimal problems. It was during the late

'20s that one of the major drug companies replaced morphine in its cough syrup with a "new and much safer synthetic substitute" called heroin. In less than five years, this was replaced by codeine, still in use today.

The use of cocaine is now practically endemic. In the early '30s, except as previously noted by Sherlock Holmes, its primary use was a topical anesthetic in eye, ear, nose and throat surgery. As a capsule, it was prescribed orally to stop the severe nausea and vomiting of early pregnancy. And now we are trying to justify the use of Bendectin®. In regard to addiction, each of us saw our share of patients with faked colic, false hematuria or severe arthralgia. We also saw the usual ones who had lost an important prescription or whose physician was not available in today's emergency. With practice, many of us recognized this type of clientele for what they were, but facilities for therapy were almost nonexistent. Mainlining, in general, was not a problem, and neither was pot. In regard to alcohol, many families had beer with meals, and the children were

“There was no charge for calls from 8 am to 4 pm, 50 cents from 4 pm to 10 pm and \$1 thereafter to 8 am.”

permitted an occasional taste.

Even though my training was in Ob/Gyn, and I was board-eligible, I could not earn a living as a specialist, so I went into general practice, becoming a “lodge physician,” the equivalent of an early HMO. The panel members paid me 25 cents a month per family for complete care. A few years later, unnecessary housecalls became too burdensome. The administration decided to add a compulsory patient-participation service. There was no charge for calls from 8 am to 4 pm, 50 cents from 4 pm to 10 pm and \$1 thereafter to 8 am. These charges decimated the housecalls, and the only ones received thereafter were when there was a really sick patient. This strongly suggests where our current policy should go in regard to insurance costs and patient participation.

My wife and I were engaged for almost seven years, and marriage did not occur until I was established in practice. There was only one married student in my graduating class, and several of the instructors let it be known that they firmly thought that no student could properly devote adequate time to learning skills, and still care for his family. (Please note I did not say “duties”). At this time my fiancée was a school teacher; the local board of education ruled there could be only one wage earner in a teacher’s family. Therefore, the only married teachers were males, as we assumed their wives were just housewives. Married females were compelled to resign. This

probably was a preliminary view of the current ERA problem.

Fortunately for me, my wife-to-be also worked as a life guard, and during the summer preceding our wedding she earned enough to furnish our apartment.

When war was declared, I had minor surgery to make myself supposedly fit. The Navy commissioned me, but I was still unfit for sea duty and was assigned for about two years to recruiting and induction in Pittsburgh. The biggest problem during this assignment were the attempted scams by people hoping to avoid the draft. They plied the station’s crew with gifts, gratuities, meals, etc. Several of my corpsmen paid no fees for meals, laundry or room rent. In general, and unfortunately for the local groups, these scams did not work. Eventually orders for sea duty did arrive, and I again became a doctor. My tour of duty was in the western Pacific, where I participated in a couple of landings, and our ship was one of the first to enter Japanese waters shortly after the bomb was dropped, and prior to the official armistice. I made one brief air inspection trip over the smoldering ruins.

There are other topics which I could present, but time and space do not permit. May I merely conclude that I enjoy the practice of medicine, and am worried about the increasing costs of getting a satisfactory education, about the medico-legal problems which inhibit proper training after the student has received his or her

education, and the government interference which sooner or later will dictate what each of us should and must do, to the detriment of sick patient. We can ask consumers, as requested, to participate in discussions of problems, but the final answers must be by the people on the firing line, and these are physicians. **OSMA**

President’s Page . . . continued

provides us with a written record of the amount of free care physicians offer to the indigent. In these days of talk of mandated assignment, we need to have a plan that will address this issue.

Another item of unfinished business is the OSMA Cancer Committee. I reactivated this committee so that it could become a focal point for cancer-related problems. One major item on its agenda is developing a list of standards on the issue of entrepreneurship regarding cancer centers.

The Task Force on AIDS, the fallout from the Ohio Supreme Court ruling on the statute of repose — these are just a few of the items on which we plan to have closure by Annual Meeting. At that time the House of Delegates of the OSMA will once again help set a new agenda for the association and we will set our sights on those goals.

It is important for all of us to remember, however, that the best of resolutions can only be transformed into action by a unified team. We need physicians

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What's New in Surgery

Editor's note: This article, a roundup of the latest surgical developments, was submitted through the American College of Surgeons, and its State Committee on Trauma. All of the authors represented in this article practice at Cleveland Metropolitan General Hospital.

Cardiothoracic Surgery

The controversy continues concerning the role of myocardial revascularization for ischemic heart disease. Increasing numbers of patients are being subjected to coronary angioplasty and this approach is now being applied to patients with multiple vessel disease. There have been calls in many circles for controlled trials comparing long-term results and costs of coronary angioplasty vs. those of coronary bypass surgery. A small but definite number of patients will require urgent surgery following angioplasty and this should be undertaken only in the setting of readily available surgical capabilities.

It has become clear that the use of the internal mammary artery for coronary bypass grafting provides a much superior patency rate and seems to confer increased longevity to patients. Expanded use of bilateral mammary artery grafts in singular and sequential fashion has been reported and appears to be a valuable adjunct to surgical myocardial revascularization.

Concern continues to be voiced over the durability of porcine

heterografts in the young adult population. Increasingly apparent are the failure rates for these valves and their use probably should be restricted to those patients whose life expectancy is limited and who cannot undergo permanent anticoagulation.

Direct cytologic and histologic staging has been shown to be necessary despite advances in radiologic maneuvers to ascertain the stage of bronchogenic carcinoma. New radiotherapeutic and chemotherapeutic regimens seem to have favorable effects on advanced adenocarcinoma and large cell carcinoma of the lung. Increasing use of the laser in the tracheobronchial tree has brought about an ability to palliate patients with far advanced bronchogenic malignancy in a simple and safe manner.

Despite the adverse publicity concerning the use of the artificial heart, many centers are effectively utilizing this device as a bridge between heart failure and cardiac transplantation. The ethical and scientific barriers of the totally implantable permanent artificial heart remain controversial. —
Norman Snow, MD

Oral and Maxillofacial Surgery

Recently, new technologies have become available in the area of Oral and Maxillofacial Surgery. The technique of rigid internal fixation is now utilized both in the treatment of facial trauma as well as in the elective facial osteotomies that are done. Prior to this, either traumatic or elective fractures of bones were treated by stabilization and internal fixation. The stabilization usually being of jaw by means of wiring the teeth together and the internal fixation usually of stainless steel wires. Because of the inherent mobility in the segments, the immobilization usually took place over the eight weeks of healing the bone. Recently the techniques in primary bone healing using compression bone plating have allowed for changes in the treatment of these fractures. This has gone over into the area of facial reconstruction as well. Small bone plating systems with varying configurations of strong but thin metals, such as titanium, are used to place the bony fragments into intimate apposition. Secondary to bone healing, which was the case prior,

has now been supplanted by mostly primary bone healing, with little or no callous formation. This has allowed not only for more rapid bone healing, it has allowed for less intermaxillary fixation to aid in the healing. Therefore, immediate function of the segments can be allowed. This has cut the time of intermaxillary fixation from 6-8 weeks down to a minimum of 0-3 weeks, depending on the fracture or osteotomy being treated. It has revolutionized the areas of treatment of facial trauma and facial reconstruction.

— *A. Thomas Indresaro, MD*

Endoscopic Laser Recanalization

It is expected that in 1986 there will be 140,000 new cases of colorectal cancer. Colonic neoplasms will account for 98,000 cases; right colon 34.6% (33,900), transverse colon 8.8% (8,624), and the left colon, including the rectosigmoid area 56.6% (55,468). Rectal carcinoma will account for 30% of the total number of cases (42,000). Obstructing left colonic carcinomas will account for approximately 15% of the total and will approach 8,000 cases. The presence of high grade obstructing left colonic lesions obviates a formal bowel prep and results in the creation of a decompressive colostomy or in some instances a primary resection and colostomy. These patients then require either one or two more procedures to fully restore intestinal continuity. Two and three stage procedures are associated with a morbidity and mortality rate of anywhere from 20%-40% and 13%-24% respectively. The risk of large bowel obstruction secondary to carcinoma increases with age and is over 20% in patients 80 years of age or older. The in-hospital mortality rate for patients with obstructing colon carcinomas can approach 20%.

The Neodymium:YAG laser has

demonstrated its efficacy in restoring luminal patency in those patients with obstructing and unresectable esophageal, bronchogenic and colorectal malignancies. Logical extension of this application to obstructing left colonic carcinomas would allow for an adequate bowel prep and subsequent formal resection with primary anastomosis, thus avoiding one or possibly two further operative procedures and hospitalizations. It has been well documented that anastomoses performed with unprepared bowel can lead to a dehiscence rate (anastomotic) of up to 40%. The use of the laser for luminal recanalization can allow for a satisfactory bowel prep and reduce the number of procedures necessary per patient, the overall hospital stay and cost, and the loss of time from employment.

Between 1984-1985 four patients were evaluated using the Neodymium:YAG laser for recanalization followed by subsequent primary resection and anastomosis. Four age-matched controls were used for a comparative cost analysis. There were no mortalities and no intra-abdominal sepsis or wound infections noted. What was evident in the comparison between these two groups of patients was the pre-operative length of stay and the total hospital costs. The pre-operative length of stay was defined as that period the day prior to either laser therapy (L/PR) or performance of a decompressive colostomy or primary resection with colostomy (DC/SR), and the intervening period between the initial procedure and either their primary resection or colostomy closure. The intra-operative period was defined as that period including only procedural days and the post-operative period was defined as those days following the primary resection or the closure of the colostomy and until 24 hours after

the patient was on a regular diet. The mean pre-operative length of stay in the laser treated group was 3.5 days as compared to the group undergoing decompressive colostomy with a mean of 15 days. ($p < 0.001$) The length of stay post-operatively for either group was not significantly different. The cost analysis for each of the subgroups showed that the group treated with the laser had a mean pre-operative cost of \$2,413 as compared to the staged procedural group which had a mean cost of \$11,105. ($p < 0.001$) Intra-operative and post-operative costs were not significantly different. The total hospital costs in the laser group was \$17,570 as compared to the staged group of \$27,532. ($p < 0.01$)

Although the numbers for this preliminary study are rather limited, several conclusions are evident: 1) the Neodymium:YAG laser can be used safely and effectively to establish luminal patency in patients with obstructing left colonic neoplasms; 2) there is a reduction in the number of pre-operative days L/PR vs DC/SR ($p < 0.001$); 3) the diminished total hospital costs are obtained in the pre-operative period (\$2,413 vs. \$11,105) ($p < 0.001$); 4) the intra-operative and post-operative costs were not significantly different; and 5) there is a reduction in total hospital costs (\$17,570 vs. \$27,532) ($p < 0.01$). Theoretically, if 8,000 patients were managed with L/PR a potential cost savings for the pre-operative period of \$69,536,000 might be realized. Psychological trauma from the colostomy and the potential loss of wages might be obviated with L/PR. Only a large prospective, randomized study will be able to ascertain whether or not this trend in the decrease of hospital days and costs, and if the morbidity and mortality is less than or equal to the current surgical approach is real. — *Marc L. Eckhauser, MD*

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Second Surgical Opinions

At the 1986 OSMA Annual Meeting, Resolution 5-86 was referred to OSMA Council for consideration and report. The text of Resolution 5-86 is as follows:

MANDATORY SECOND OPINION

“RESOLVED, That the Ohio State Medical Association consider it inappropriate and unethical for the physician rendering a required second opinion to assume continuing care of the patient.”

The Council chose to send the resolution to its Judicial and Professional Relations Committee for recommendations.

The Committee, chaired by S. Marcus Wigser, MD, Cincinnati, after discussion and review of

relevant policies and reports of the AMA and the OSMA, offers the following guidance for patients and physicians involved with second surgical opinion programs.

(1) The JPR Committee recognizes that OSMA House of Delegates policy opposes mandatory second opinion programs.

(2) Second opinions, when appropriate, are valuable to the patient and to the physician.

(3) A patient has an unqualified right to a second opinion if he or she requests one.

(4) When time permits in non-emergency situations, the third-party payor should furnish the second opinion physician with a statement from the first opinion physician specifying the basis for the first opinion.

(5) Second opinions should be furnished by physicians who have experience with a patient's particular disease or problem. (Please see AMA Resolution 28; I-86) However, second opinion physicians need not be of the same specialty as the first opinion physician.

(6) The patient should always have the ability to request care from whichever physician he or she chooses.

(7) If a second opinion is mandated by a third-party payor and the patient wishes to transfer his care to the second opinion physician, the patient should be required to inform the first opinion physician and the third-party payor of his decision. The committee recommends that third-

continued on next page

Second Surgical Opinions . . . continued

party payors prohibit, by contract, the second opinion physician from taking on the continuing care of the patient, unless the patient specifically requests the transfer. The committee also recommends that, where a second opinion is mandated, the second opinion physician should be required to direct the patient to return to the first opinion physician for a discussion of the second opinion. This discussion should occur at the third-party payor's expense.

(8) Unless the patient prohibits the communication, physicians offering second opinions in a voluntary situation should inform the patient that they wish to discuss the second opinion and analysis with the first opinion physician.

The following physicians serve on this committee:

S. Marcus Wigser, MD,
Cincinnati
Alcuin D. Bennett, MD, Toledo
David Jackson, MD, Columbus
William H. Kose, MD, Findlay
Marvin S. Platt, MD, Akron
Peggy-Jeanne St. Clair, MD,
Cleveland
John H. Sanders, MD,
Cleveland
Robert F. Sanke, MD, Alliance
Robert K. Seidel, MD, Akron
Jerome R. Sheets, MD,
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R. Donald Woodson, MD,
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Progress in the Treatment of Trauma: Plastic and Reconstructive Surgery

Introduction: The most significant recent advance in reconstructive plastic surgery for trauma is in the area of extremity salvage. Two advances have been particularly significant. These are: (1) the delineation of arterialized tissues — primarily muscles — that can be used for reconstruction of traumatic (and other) tissue defects, and; (2) the development of microsurgical techniques by surgeons experienced in replantation surgery (replacement of amputated extremities and their distal portions — hands, feet, digits) that has lead to the establishment of a new surgical subspecialty, reconstructive microsurgery.

Soft tissue coverage of traumatic wounds: The reliability of present techniques of wound closure represent a marked improvement over traditional methods and have greatly extended the scope of reconstructive surgery.

Muscle flaps may be transferred with attached overlying skin and subcutaneous tissue. More commonly, however, muscle only is transferred into a defect and skin grafted. Rather surprisingly, this provides quite reasonable cosmetic appearance. Bulky at first, denervated muscles used in reconstruction eventually atrophy and undergo a "self contouring" effect. Muscle flaps are used in one of two ways:

(1) One end of the muscle is left attached with its primary vascular pedicle intact. The muscle with or without overlying skin and subcutaneous tissue is then rotated into the tissue defect. Long muscles such as the rectus abdominis, for example, may have a large "arc of rotation"; this muscle may be used to cover defects as far away as the upper chest or the thigh.

(2) Reconstructive microsurgery permits the use of arterialized tissue as "free flaps" without the limitations of the arc of rotation of a pedicled flap. The flap to be used is dissected free and moved into a distant defect. Its circulation is then reestablished using microsurgical techniques. Success rate of such microsurgical transfers approaches 100% for traumatic cases; this method of "instant wound closure" is now preferred when local tissue is not available as in distal parts of extremities. The lower leg especially is frequently the site of large combined skeletal and soft tissue defects (type IIIB and IIIC fractures), the result usually of motor vehicle and motorcycle accidents. Not only can these defects be closed rapidly but orthopedic procedures — fusions and bone grafting — may often be carried out simultaneously.

There are other injuries in which early soft tissue coverage is indicated. Electrical burns, for example, are usually deeper than initial evaluation suggests. In the past these wounds were treated with debridement and expectant waiting. This was often associated with loss of limbs. Acute debridement and immediate coverage (within 72 hours) with free muscle flaps may salvage extremities that otherwise would be lost.

Finally, two points should be emphasized (1) the reconstructive surgeon can not work in a vacuum. Salvage of severely injured extremities requires a team of surgeons capable of providing all aspects of care, skeletal management, vessel reconstruction, and care of associated injuries, and: (2) early wound coverage has decreased complication rates — primarily infection and loss of transferred tissue — as well as recovery time. This alone is ample

indication for early involvement of a plastic surgical team in the treatment of open injuries.

— A. Scott Earle, MD

Teen pregnancy . . .

continued

some other arrangement.

"Fortunately, returning to school is the norm in our program," she says.

- Counsel mothers about child development. "As the baby gets older, teen mothers may find their infants getting on their nerves," says Dr. de Levie. Consequently, they may offer inappropriate discipline — and may even become abusive. "Let the mothers know that their babies go through very natural stages — that when an infant pulls at the mother's hair, it's nothing personal."

- Offer continuity of care, an especially important consideration for this age group, says Dr. de Levie — "which may not really open up until after a year's worth of care."

Finally, she recommends that physicians encourage mothers to prevent further pregnancies.

"Teenage pregnancy may be *the* major social problem of the U.S. today. That's why prevention is essential. By the time the baby is born, it's too late to begin finding solutions to the problem." —

Karen S. Edwards

President's page . . . continued

to become proactively and enthusiastically involved in committee service, membership and the local political arena.

To act forceably, we need numbers — not only in dollars but, more importantly, in an active and committed membership. I sincerely believe that if Ohio physicians take time to consider the options at this juncture and if they act in a concerned and proactive fashion, then and only then can we **BE IN CHARGE IN '88**.

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Telephone orders for classified ads are not accepted.

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1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. The *Journal* will assume \$10 of this expense and the author will be billed by The *Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

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(d). The author must affirm that he has written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

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7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

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"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

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"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

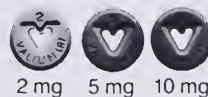
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10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at \$2 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. The *Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Ms. Deborah Athy, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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VOL. 84, NO. 2

FEBRUARY, 1988



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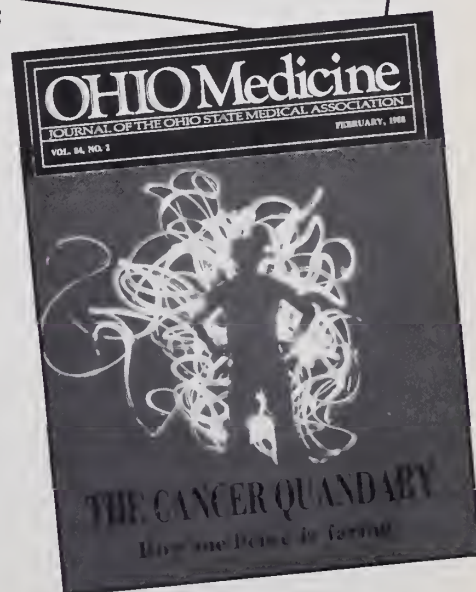
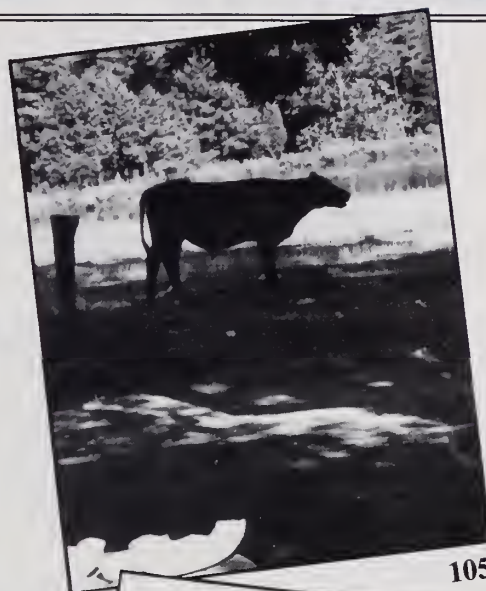
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OUR COVER

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FROM THE EDITOR

A Reawakening Interest in Cancer?

This month, OHIO Medicine shifts its attention to a clinical subject — one which, in view of the recent furor over the AIDS virus, has taken a back seat for awhile.

Like AIDS, it, too, strikes fear in patients and patients' families when the diagnosis is pronounced. Like AIDS, it, too, relentlessly kills its victims. But, unlike AIDS, the medical profession is beginning to gain some ground in managing this disease — in getting at least some aspects of it under control. Yet, the profession's battle with cancer is hardly over.

Our opening article, by Associate Editor Deborah Athy, takes a look at just how far medicine has come in controlling cancer. "Cancer in Ohio" brings you up-to-date on cancer statistics, testing procedures, and some new treatments currently in use. It also provides you with information on which cancers are "under control" — and which are not.

Spinning off from that article is a piece which takes a closer, more in-depth look at breast cancer screening centers in the state. Editorial Assistant Michelle Carlson investigates the operations of these centers, who runs them — and whether these facilities are helping or hindering the medical profession.

Finally, we try to determine whether or not there is a

reawakening interest in cancer, both on the part of the public and the medical profession. We'll take a look at OSMA's reactivated Cancer Committee and try to determine what goals they hope to achieve this year, and in the future . . . and we'll also explore just how far the medical profession might be able to go in managing this disease. Will there be fewer cases in the future — or will there be more, as other fatal illnesses come under control, and as the population in this country continues to age?

One last note . . . please don't forget that OHIO Medicine is always looking for contributors to its Letters page, its Second Opinion column, as well as good clinical pieces to run in our Scientific section. Essays are also wanted — and if you have a good idea for a Medi-scene article or for someone to feature in our "Out-of-Practice" column, we'd like to hear from you. OHIO Medicine is your publication — why not become a part of it?

Karen S. Edwards



“An Affair of the Heart”

By D. Ross Irons, MD

Few topics, if any, so stimulate the cardiovascular system of today's physician as that of professional liability. Even Cupid takes a backseat when the threat of a malpractice suit rears its ugly head. This everpresent cloud has been cussed and discussed ad nauseam at all levels — local, state and national — and as of this date it appears that no quick and easy cure is in the offing.

The old standby, tort reform, has enjoyed some success here in Ohio due to the successful efforts of the legislation (HB 327) introduced by OSMA and subsequently passed by the Ohio General Assembly. At the Federal level, even the General Accounting Office has recognized this as a national problem and has made some general recommendations for suggested legislation.

However, the problem with the general tort reform efforts is that the tort issue is really not a homogenous entity. Certainly, medical tort reform differs from product liability or personal injury reform. Furthermore, each state has different laws addressing this issue, and, as we all know in Ohio, different court interpretations of those laws. The Ohio Supreme Court decision,

Hardy vs. VerMeulen, handed down in August, 1987, severely impacted Ohio's statute of limitations for medical claims. Without an appropriate statute of limitations, Ohio physicians have an unlimited risk of liability exposure. Although the Ohio General Assembly agrees that a statute of limitations for medical claims cases is appropriate, four of the seven members presently sitting on the Ohio Supreme Court disagree.

The diversity of forces influencing the medical liability climate means that each state must seek relief for this problem in innovative and individualistic ways.

We have several alternatives available to us in Ohio. First, we could seek reactivation of the Joint Underwriting Association. As you may remember, the JUA was established in 1976 to offer medical professional liability insurance to physicians and hospitals who could not find it in a shrinking liability marketplace. During this time period the OSMA and Ohio physicians worked hard to create new markets for medical liability insurance through the creation of PICO and other physician liability carriers. The JUA ceased writing medical

liability insurance in 1980 after a strong market re-emerged.

By re-entering the medical liability market, and creating another source of liability insurance, the state would be assisting in the availability of medical liability insurance. It is important to keep in mind, however, the problems today are one of availability of appropriate coverage limits and product availability, such as occurrence over claims-made. The current trends in the medical liability marketplace indicate a reactivated JUA would function in an environment of increasing frequency of claims filed and increasing awards that all medical liability companies must face. This results in an ever-increasing cost of medical liability insurance.

Another possibility is the establishment of a patient compensation fund. A number of states have enacted legislation to create patient compensation funds to serve as a backup to traditional medical liability insurers. A patient compensation fund, appropriately financed, could bring relief to Ohio physicians by providing coverage for claims that exceed the coverage available in the private marketplace. Furthermore, a

continued on page 90

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of Tagamet*.

Precautions: While a weak antandrogenic effect has been demonstrated in animals, Tagamet* has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving Tagamet*.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of Tagamet* HCl [brand of cimetidine hydrochloride] Injection by intravenous bolus.

Symptomatic response to Tagamet* therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

Tagamet* has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlorthalidoxime, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when Tagamet* is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either Tagamet* 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. [Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.]

Lack of experience to date precludes recommending Tagamet* for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states [e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation], predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving Tagamet*, particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in Tagamet*-treated patients [approximately 1 per 100,000 patients], including agranulocytosis [approximately 3 per million patients], have been reported. Including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia [approximately 3 per million patients] and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving Tagamet* has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 [intended for institutional use only]; 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 [intended for institutional use only]; and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 [intended for institutional use only].

Liquid: 300 mg./5 ml., in 8 fl. oz. [237 ml.] amber glass bottles and in single-dose units [300 mg./5 ml.], in packages of 10 [intended for institutional use only].

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

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AIDS out of the closet

To the Editor:

My sincere congratulations to Dr. Stanley Fox on his article *AIDS: Lets Get it Out of the Closet* (*OHIO Medicine*, November, 1987) and my gratitude to the editors of the Journal for printing this article that "tells it like it is."

I have always had great respect for the CDC and the United States Public Health Service. CDC has done outstanding work in the field of epidemiology and infectious diseases, and I can think of no organization that has done more to promote and foster the health and welfare of the people of the United States than the U.S. Public Health Service. I cannot, however, accept their policies and recommendations in regard to AIDS.

The handling of the AIDS epidemic by CDC and the Public Health Service (PHS) will be remembered as the biggest mistake in the history of medicine. By not following up on the sexual contacts of people with AIDS, people with ARC, and people with a positive AIDS virus antibody test, CDC and PHS are knowingly permitting these infected people to transmit a universally fatal disease. This is not only bad medicine, but in my opinion, this is criminal.

From the very beginning of the AIDS epidemic CDC and PHS abandoned the principle of epidemiology expressed by Dr. C.L. Anderson in his book *Community Health* that, "In an epidemic the unit is not the individual but the population."

CDC and PHS also abandoned proven epidemiological and scientific methods of contact tracing and notification and developed guidelines to protect the rights and confidentiality of the infected individuals instead of

protecting the general population from this devastating universally fatal disease AIDS.

I have been a proud member of AMA and OSMA for 36 years. During this time we have always championed the cause of the sick and downtrodden, we have always fought to protect the health, lives and welfare of the people of our country, and we have fought to keep medicine free from outside intervention. Recently however, the American Medical Association has, in my opinion, "sold us out."

At the present time, we are not free to screen risk groups. We are not free to follow up on contacts, we cannot screen people who are participating in contact sports, we are not free to screen food handlers, we are not free to screen pre-maritals and pregnant women. We are not free to practice good medicine without the fear of litigation.

I cannot believe that, we as physicians have permitted non-medical personnel, the gay activists, lawyers, legislators, etc. to implement laws, recommendations and guidelines in handling AIDS cases that are not only against my conscience but also against my medical judgment.

To become free again to practice medicine as we see fit we must work to enact the following legislation:

1. Make AIDS virus infection identified by positive AIDS antibody tests a reportable communicable disease with mandatory follow-up and screening of all sexual contacts of these AIDS antibody-positive patients. This would include people with AIDS, people with ARC, people with other manifestations of the disease and people who are

asymptomatic but do have a positive AIDS antibody test.

2. Pre-marital and pregnancy screening for AIDS is essential in the prevention of the transmission of AIDS in the heterosexual community (spouses and children).
3. Routine screening of prostitutes, food handlers, pre-employment, contact sports participants, immigrants, service care workers (barbers, beauticians, masseurs, etc.) and hospital admissions should be seriously considered.
4. AIDS is a medical problem, not a social issue, political issue or civil rights issue. Furthermore, confidentiality is ingrained in all physicians from the first day of medical school and is part of us for the rest of our lives and any restrictions placed on physicians in the name of the above issues should not be tolerated.

More men ages 20-49 have died from AIDS in San Francisco than died, from that city, in the San Francisco earthquake, WWI, WWII, the Korean conflict and in Vietnam combined. Isn't it about time that all practicing physicians band together to bring this devastating disease under control before it destroys us all?

J. Nicholas Gordon, MD
Atlanta, Georgia

A throwaway?

To the Editor:

I am concerned about the fact that the *Journal of the Ohio State Medical Association* is beginning to look like the "throwaway journals" that we frequently receive in our office. A good example is your November issue. I wonder what the postmen who,

continued on page 90

out of curiosity, glanced at the front page and got the impression that we, as physicians, are nothing more than a marketable item. I especially objected to the insinuation that a good physician is "willing to make house calls" and, therefore, has "eager feet."

I was also not overjoyed to see that the back page of the magazine is now being used for advertising medications.

I would expect our own State Medical Association to act in a more professional manner. I am somewhat disappointed in your editorial judgment and would hope that you and your staff would reassess the goals of our *Journal*.
Raymond G. Russell, MD
Miamisburg

Student to Student

To the Editor,

Regarding the content of the editorial printed in the December 1987 edition of *OHIO Medicine* entitled Student to Student, we are disappointed by the inaccurate information and implications presented by the author David Voigt. Mr. Voigt suggests that he:

1. solely originated the concept of a student-run medical speakers bureau for elementary through high school students.
2. independently approached the Student Affairs office at the Medical College of Ohio to elicit approval and support for the implementation of a student speakers bureau.

Besides these, there are numerous other inaccuracies within his letter. Concerning the major implications outlined above, we submit the following response.

While Mr. Voigt's concern for public education has never been in doubt, he is ignorant of the fact that medical students throughout Ohio and other states have student

speakers bureaus. Many of which have been in existence previous to his claimed "unique" concept. Therefore, his claim of originality is obviously false.

Mr. Voigt's recollection of our interaction with the Student Affairs office is also inaccurate. Richard Steinman and David Voigt consecutively and in this sequence, approached the Student Affairs office after multiple previous discussions among themselves about the formation of a student speakers bureau. Thus, his claim that a preformed organization requested OSMA support is fallacious.

While it is true that Mr. Voigt has been an active local leader and participant in the Student to Student Community Health Education Program at the Medical College of Ohio (MCO), it is NOT TRUE that he organized this concept in any way at the state or national level. Richard Steinman and Naakesh Dewan further developed the Student to Student concept at MCO and initiated a well-organized community education program at the state level under the guidance and support of the OSMA/MSS and OSMA. This program has developed into the nationally-recognized Student to Student Community Health Education Program. This program currently addresses the following topics, some of which vary from medical school to medical school:

1. The Human Brain
2. The Human Heart
3. The Human Lungs
4. The Dangers of Smoking
5. The Dangers of Drug and Alcohol Abuse
6. How to Become a Medical Doctor
7. AIDS: The Facts and The Fiction, and
8. The Facts about Teenage Pregnancy.

It is indeed unfortunate that the

original article misstated whose wife is an elementary school teacher, but this was an unacceptable reason for Mr. Voigt to submit an inaccurate history of events concerning a very worthwhile project which provides for the community's well-being. Respectfully yours,
Naakesh Dewan
Richard Steinman
Derrick Jeter
(OSMA/MSS President)

President's Page . . . continued

patient compensation fund could provide relief from the negative impact of the *Hardy vs. VerMeulen* case by relieving the private medical liability insurance companies of the indefinite exposure to lawsuit brought about when the court ruled the statute of limitations unconstitutional. However, physicians must be protected from an unfair burden of financing any type of system.

In addition, the OSMA will need to investigate the feasibility of the approach recently recommended by the AMA/Specialty Society Medical Liability Project. This proposal calls for a fault-based administrative system, under the jurisdiction of strengthened state medical boards or a new state agency, which would totally replace the existing court/jury system.

Lastly is a notion that I believe we need to investigate more closely — so-called "trip insurance." This would work much like the present system of airline flight insurance. Before a particular procedure is performed a patient would have the option of purchasing insurance to cover that medical encounter. In view of the litigious attitude of the American public and their continued demand for a "perfect"

continued on page 147

Socialized Medicine:

The downfall of a free society

By *N.M. Camardese, MD*

I urge every American practicing physician to correspond with the President of the United States and our elected officials regarding the enactment of Public Law 99-509 (Omnibus Budget Reconciliation Act of 1986). Below is a copy of the letter I personally sent to President Reagan regarding my views on this onerous law. If doctors do not preserve and protect the freedom of the private practice of medicine and patients' rights, then who will?

Dear President Reagan:

Lenin stated that medicine is the key to Socialism.

Over eight years ago or so, when I was privileged and honored to meet you personally — as you spoke to the Association of American Physicians and Surgeons, at Denver, Colorado — you extolled, as you have always, the virtues of free enterprise; and you decried the evils of socialized medicine and what it would do to America.

Socialism, bureaucratic over-regulation, and collectivism — by whatever name(s) — are a form of statist tyranny.

As government expands, freedoms contract.

History records that of 21 major civilizations, 19 fell from corruption from within; bureaucratic over-controls; government plunder; demoralization; and ultimately statist tyranny.

It is hard to believe that your advisers would have tricked you into signing into law, Public Law 99-509.

Since the onset of Medicare, medical costs have sky-rocketed to about \$450 billion annually.

And now Congress proposes to cut costs by rationing medical care and socializing American medicine.

What a tragedy!

History also records that whenever and wherever socialized medicine has been tried — it has resulted in demoralizing doctors; deteriorating medical care; sky-rocketing costs; rationing medical care; and an overall depersonalization of all involved.

Surely, your administration which espouses free enterprise so much, will not tolerate such outrageous developments.

Why not return medical care to self-care — by vouchers and/or 'local' solutions.

Government has absolutely no

business in practicing medicine. It smacks of a command society.

'Tis never too late to do the right thing and always too early to do the wrong one.

Public Law 99-509 ought to be repealed:

1. It violates Article XIII of the U.S. Constitution (Involuntary Servitude).
2. It violates the most basic of Constitutional Human Rights — the Liberty to Contract (clause) between two people without undue coercion and/or restriction.
3. It is, in essence, a "Bill of Attainder."

A nation is not free if one "segment" is under tyranny.

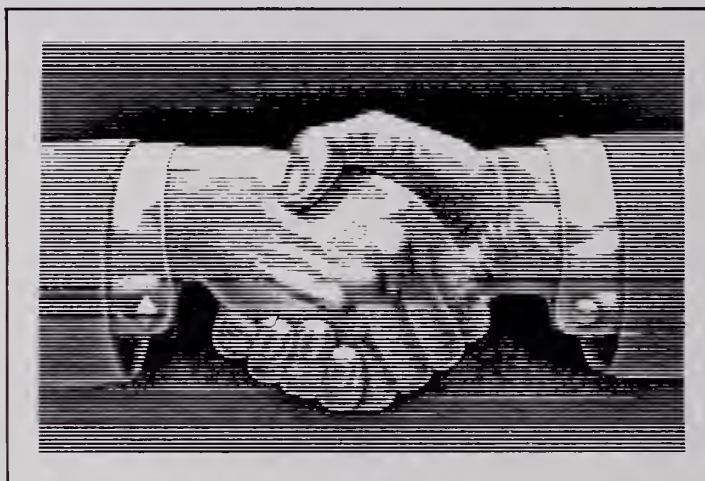
America is not free if medicine is under statist tyranny.

It is ludicrous for medical societies to get together to waste efforts, monies, resources, time, and health to have to sue our government for having over-stepped and abused its limited powers; violated Constitutional provisions.

It is even more ludicrous and brazen for our elected and appointed officials to arrogate fraudulently unto themselves the

continued on page 147

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Early testing for AIDS

A test capable of detecting the human immunodeficiency virus (HIV) *before* antibodies to the virus have developed has been initiated by a team of Chicago researchers, says a recent report in the *Journal of the American Medical Association*.

The test, which was developed by Harold A. Kessler, MD, of Rush-Presbyterian-St. Luke's Medical Center, and colleagues, uses an enzyme immunoassay to detect acute HIV infection, a precursor to chronic HIV infection.

JAMA reports that the test, which detects HIV antigen (HIV-Ag), was performed on four homosexual men, all of whom tested seronegative when they sought treatment. Of the four, two tested positive for the antigen during their acute illness. All four later tested positive for HIV antibodies.

According to the researchers, "... Serum HIV-Ag detection has the potential to be a rapid diagnostic test for acute HIV infection before the development of (HIV antibodies)."

While additional testing will no doubt be required, researchers have every reason to be optimistic that the test will eventually be used for early detection of HIV. Up until now, testing has only revealed those individuals who have developed HIV antibodies — something that has been estimated to take anywhere from six weeks to six months after becoming infected.

Cutting kids' calories

It's no secret that Yuppies — those well-educated, affluent, often health-conscious members of society — have long snubbed their noses at Twinkies, Big Macs and other so-called "junk foods," favoring instead a diet of low-calorie, low-fat "health foods."

But according to a report published by the Cleveland Clinic Foundation, some well-intentioned parents who subject their children to such a diet may actually be starving their children of necessary nutrients.

According to the report, some parents are attempting to protect their children from the dangers often associated with saturated fat and obesity by denying them meat, fat and other high-calorie foods,



and instead are offering them fruits, vegetables and low-fat dairy products.

Cleveland Clinic Foundation nutritionists warn, however, that such a diet does not provide infants with the calories they need to grow normally. For growing children, they say, a well-balanced diet should include high-calorie, high-energy foods such as whole milk, meat and an occasional cookie or candy bar.

Changing an image

A nationwide advertising campaign meant to educate the public about birth control pills has been rejected by all three major television networks, according to a national press release.

ABC, NBC and CBS reportedly refused to air the thirty-second advertisements, which are sponsored by the Association of Reproductive Health Professionals (ARHP) and Ortho Pharmaceutical Corporation, because the spots violated their policies regarding the airing of contraceptive commercials.

According to ARHP President Michael Burnhill, MD, the campaign "was developed in a climate of widespread national confusion about . . . birth control.

The United States has one of the highest unintended pregnancy rates among the world's industrialized nations. That's why a public education campaign that reaches Americans directly . . . is so critical."

The advertisements do not urge women to use the Pill, but rather inform them that the Pill has undergone some changes since its initial introduction 25 years ago — namely, a significant reduction in dosage.

While television may not be ready for contraceptive advertising, the print media apparently is — *Time*, *USA Today*, *Parade*, *Newsweek* and a host of women's magazines have all accepted the advertisements for publication.

COLLEAGUES IN THE NEWS

JOHN B. MARSHALL, MD, Shaker Heights, has been named director of the department of medicine at St. Luke's Hospital . . . **BENNIS E. GRABLE, MD**, Lodi, has been elected president of Lodi Community Hospital's medical staff . . . **JOHN HUTTON, MD**, Cincinnati, vice-chair of basic science research at Children's Hospital Research Foundation, has been appointed as 45th dean of the University of Cincinnati College of Medicine . . . **LEON GOLDMAN, MD**, La Jolla, director of Jewish Hospital's Laser Center, has received the 1987 Friedlander Award, which is given annually to the individual who best exemplifies Jewish Hospital's pursuit of excellence. Dr. Goldman is often referred to as the "Father of Laser Medicine" . . . **RICHARD M. RANSOHOFF, MD**, Cleveland, has been awarded a Harry Weaver Neuroscience Scholar Award from the National Multiple Sclerosis Society. Dr. Ransohoff will receive \$293,465 over a five-year period to study how immune responses in the brain may trigger multiple sclerosis . . . **CHERYL CRISTENSEN, DO**, Cincinnati, has been elected to co-chair the American Occupational Medical Association . . . **EMILY HESS, MD**,

Cincinnati, has received the 1987 Daniel Drake Humanitarian Award given by the Cincinnati Medical Foundation . . . **STANLEY TROUP, MD**, Cincinnati, has been appointed to a 14-member committee that will advise Congress on ethical issues that arise in the delivery of health care and in biomedical and behavioral research . . . **MARC N. LOUNDY, DO**, Randolph Township, has been elected president of the Dayton District Academy of Osteopathic Medicine . . . **LEO WALZER, MD**, a Shaker Heights internist and cardiologist, has been named 1987 Physician of the Year by the board of trustees and medical staff of Suburban Hospital in Warrensville Heights . . . **LAWRENCE MYSLIWIEC, MD**, Athens, has been named a full-time associate professor of orthopedic surgery at Michigan State University . . . **WILLIAM ABRAMSON, MD**, Dayton, has received the 1987 Friend of the Year award from St. Elizabeth Medical Foundation. The award is given to a person or group who best exemplifies the Franciscan spirit of caring . . . **DALE WIETH, MD**, a Cincinnati plastic surgeon, has been appointed president of the medical staff at Christ Hospital . . . **SHARDA K. BOB-**

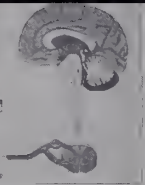
BA, MD, Circleville, has been appointed chief of psychiatry at Chillicothe VA Medical Center . . . **Y.T. CHIU, MD**, a Youngstown plastic surgeon, has been elected chairman of the board of trustees of the Northeastern Ohio Universities College of Medicine . . . **SHARI WELCH, MD**, an emergency physician at Huron Hospital Emergency Department, has been honored by the city of University Heights for rescuing an automobile accident victim . . . **RICHARD R. VILLARREAL, MD**, Wheelersburg, has been elected to a three-year term to the board of directors of the American Medical Electroencephalographic Association . . . **HERBERT DERMAN, MD**, Columbus, director of pathology at Riverside Methodist Hospitals, has been inducted as a Distinguished Practitioner of Medicine in the National Academies of Practice . . . **SYDNEY O. FERNANDES, MD**, Perrysburg, has been named chief of staff at St. Charles Hospital . . . **GEORGE W. ALLMAN, MD**, Akron, has been named medical director at Dr. Mitchell's Immediate Medical Care Center in Middleburg Heights .

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Pain pathways, page 63

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SPECIAL FEATURE

Willingway: A Fellowship in Alcoholism and Drug Addiction

OHIO MEDI-SCENE

Hospital AIDS policies . . . sexually transmitted diseases . . . malpractice dos and don'ts . . . AMA appointments . . . a new hearing device . . . predicting dangerousness . . . PICO income reports . . .

Hospitals wrestle with AIDS policies

Now that AIDS patients are beginning to appear in hospitals — in some cases, for the first time; in increasing numbers in others — hospital personnel are scrambling to formulate policy on such things as infection-control, bioethical issues and testing.

Recently, professionals from an assortment of disciplines came together to learn how two hospitals — one in Columbus and one in Dayton — are handling health care's newest dilemma.

"When we first began to see cases in 1981, the infection control committee set up the hospital's policy," says Nancy Click, Assistant Vice President, Professional Services at Riverside Hospital in Columbus.

Click was one of several speakers who addressed the subject of AIDS at a recent seminar sponsored by the Commission on Interprofessional Education and Practice.

As more information on AIDS became known, and ethical and social implications began to figure into the picture, more departments began to get involved, says Click.

However, the problem was that no single group was assigned to oversee the different decisions that were being made.

"We recognized the fact that we needed a coordinated body," she says, so an AIDS ad hoc committee was set up to identify the issues and track them.

"It was their responsibility to list the issue, name the position or unit which was responsible for handling it, decide when a report was due back from that unit, and report the status of that issue to the rest of the hospital," explains Click.

The committee also set the date for the implementation of any new policy as well as times for in-service programs.

The first AIDS issue to arise — whether or not AIDS patients should be isolated from other patients — had already been acted upon by the Director of Infection Control. However, the committee did step in to set policy on such matters as whether or not gloves should be worn and whether or not pregnant employees should be permitted to work with AIDS patients.

Other major topics addressed by the committee included:

- ensuring a safe, hospital environment. "We decided to adhere to the universal precautions set up in the guidelines issued by the Centers for Disease Control," says Click.

- testing — both of patients and employees.

- the cost of transmission prevention. "Obviously, this was an additional expense to our program, so the committee decided to recognize that expense and allocate resources to it," says Click.

- confidentiality and
- discrimination.

Yet no matter how AIDS policy is set up at your hospital, one thing is certain. It will not stay the same.

"The process (of setting policy) is evolving," says Theresa Ashe, an Infection Control Nurse at Miami Valley Hospital. Ashe, and her colleague Elizabeth Stavnitski, also an Infection Control Nurse at Miami Valley Hospital, were additional speakers at the recent interprofessional conference on AIDS.

OHIO MEDI-SCENE

AIDS policies . . . *continued*

Like Click, Ashe also advocates a broad-based committee to study the issues.

"Infection control has a narrow focus," she says. "There are a lot broader issues to consider." She points out, for example, that there are a great many patient care issues that need to be considered when developing AIDS policy — patient placement, for example.

"Should you scatter beds throughout a unit or have a designated AIDS unit?" she asks.

The advantages of a designated area, of course, are a specialty-trained staff and the "latest expertise."

"However, there is a perceived notion of isolation," she points out, adding that such isolation could become a real public relations issue for the patient as well as the hospital. Also, in smaller hospitals, or where the number of AIDS patients is low, one unit is just not feasible, she says.

She also voiced many of the same concerns that Click raised in her presentation — issues like confidentiality, testing, reporting and availability of services — all of which need to be studied and resolved by a policymaking body, but not set in stone, she says.

"We are in a continuing learning process," she adds, "and whatever policies are made need to reflect this."

Policies also need to be sensitive, says Ashe's colleague Elizabeth Stavnitski — for employees as well as the patient.

"Make employees partners in patient care," she cautions.

Many are already frightened of the disease and lack the information they need to understand that risks to health-care workers are low.

"Not all hospital employees are trained professionals. They come from different backgrounds and have different levels of education. Still, it's important to address their concerns and do so at their own level," she says.

already been pointed out, is another sensitive subject.

"We care for AIDS patients in private rooms," says Stavnitski, who acknowledges that such policy sends "bad messages" about the patients — sometimes resulting in an irrational fear of them.

"But we try to reinforce our policy with positive answers," she says. "Private rooms do protect the confidentiality of the patient." And the hospital does pick up that portion of the room charge not

Testing is one of the *big* issues that needs discussion, Stavnitski says.

Seemingly small matters, such as the availability of the kinds of supplies needed to protect employees need to be addressed — "Though that's something of a problem at this time," she notes in an aside comment, alluding to the present glove shortage being experienced by many hospitals.

Testing, on the other hand, is one of the *big* issues that needs discussion, she says.

Should testing be required as a condition of employment? What if an employee requests a test — should he or she be followed from that point? Should a test be physician-ordered, thereby making it part of the medical record and accessible to insurance companies? Decisions need to be made, she says.

Housing of patients, as has

covered by insurance companies.

Still, education — continuous education — is the key to making employees more comfortable around AIDS patients, Stavnitski stresses.

"Education is not something that's done at one in-service. We have to recognize that it is an evolving process — and let employees know that we don't know everything about AIDS, but we do know these things."

Employees need these forums she insists, and she advocates a form of "peer education" to help carry the message across.

"In our hospital we've established a system where one representative from each department meets with a member of the Infection Control

continued on next page

The facts about STD

Informing a patient that he or she has contracted a sexually transmitted disease (STD) such as gonorrhea or herpes has never been a particularly pleasant task for the physician.

More often than not, the patient is surprised, shocked, or perhaps embarrassed. At the same time, the physician may be uncomfortable with his or her role as the bearer of bad news.

It should follow, then, that telling a patient that he or she has contracted not one, but two or more STD's would be twice as difficult for everyone concerned.

Unfortunately, says Gita P. Gidwani, Section Head, Department of Pediatric and Adolescent Gynecology, Cleveland Clinic Foundation, for physicians in specialties such as gynecology, the chance that such a situation will arise is not only possible, but *probable*.

Dr. Gidwani was in Columbus recently to discuss STD's during the OSMA's annual Scientific Meeting.

"It's important to culture for everything once you think a patient has an STD," warns Dr. Gidwani. "I can never reiterate this enough — think of the other bugs at the same time." Otherwise, she says, "You may leave (the patient) incomplete if you don't look for everything."

When one considers the number of new cases of STD's diagnosed every year in the United States —

approximately 2 million cases of gonorrhea, 1 million cases of pelvic inflammatory disease (PID), 200,000-500,000 cases of herpes, and 80,000 cases of syphilis — Dr. Gidwani's recommendation is well-taken.

infections no less troubling.

"These are the patients who will pay the price later," she laments. "It's a real sad state of affairs."

While Dr. Gidwani admits she doesn't have all the answers, she does offer suggestions for dealing

Chlamydia, afflicting 3 million Americans, is "the most sexually endemic disorder."

Additional statistics she cites only serve to confirm her suspicions: Of all women who present with gonorrhea, 15 percent also have PID, which is known to cause sterility, while 40 to 60 percent may also have chlamydia.

Fortunately, antibiotics have proven highly successful in treating such diseases, and Dr. Gidwani encourages swift dispensation of such drugs as amoxicillin, ampicillin, penicillin and tetracycline. "We have to be overenthusiastic, overaggressive in our use of antibiotics," she says. "It's the only way we're going to cut down on morbidity in terms of infertility."

Still, she voices concern over the sheer enormity of the situation, calling chlamydia, which afflicts approximately 3 million Americans each year, "the most sexually endemic disorder among our young people."

She finds the fact that the 16 to 24-year age group accounts for nearly two-thirds of all gonorrhea

with adolescents who contract STD's.

First, she says, it is imperative that the physician obtain a complete sexual history — something that can't usually be done if the patient's parent is present. "You have to give your patient confidentiality because there's no way a girl is going to tell you that she's sexually active in front of her mother," Dr. Gidwani advises. "You have to separate the two (mother and daughter) before you can get a sexual history."

If the adolescent is diagnosed as having an STD, it is also important that his or her partner is treated as well, Dr. Gidwani says. Otherwise, there is a high possibility that reinfection will occur.

Finally, she says, the physician should educate the patient about the use of condoms to protect against contracting diseases in the future. "We need to tell young women that (the condom) is the way to prevent STD's," she says. "Even if you're on the Pill, a barrier is necessary if you don't know your partner."

Ultimately, she says, the spread of STD's will not be stemmed until society begins to educate — not condemn — its young adults.

"We haven't been able to cut STD's by preaching morality," Dr. Gidwani notes. "It all points to education. We really need to get this out of the closet and talk about it intelligently." — *Michelle Carlson*

AIDS policies . . . continued

department," she says. Policy matters are discussed, then each representative takes the information back to his or her respective department. In that way, housekeeper learns from housekeeper; dietitian from dietitian.

No matter how education and

policy are eventually established, however, Stavnitski makes one final point.

"Make your decisions now and have your policy in place in your hospital — *before* a problem or incident occurs," she says. —

Karen S. Edwards

OHIO MEDI-SCENE

A subject that bears repeating . . . more malpractice dos and don'ts

Although *OHIO Medicine* has brought you articles in the past which show you how to handle yourself in a malpractice suit, we feel that the information always bears repeating — especially when it is being repeated by someone with the credentials of Jerome Bettman, MD, Chairman of the Ethics Committee for the American Academy of Ophthalmology. Dr. Bettman, a California ophthalmologist, recently spoke on the subject of malpractice — and how to avoid it — at the Ohio Ophthalmological Society's Annual Meeting, held in conjunction with OSMA's "Clinical Update." Below are some of the highlights of his talk:

Reason for the rise of malpractice claims — "Public expectations have increased," he says. "The public expects to be cured." And when the news media disclose (as they regularly do, he says) the millions of dollars involved in a settlement, the environment just becomes too tempting. "There is a strong, growing tendency these days to create liability where there has been no fault," he says. "And anyone with \$50 and a typewriter can sue you."

Development of a suit — Of course, just because someone has filed suit against you doesn't necessarily mean it will go to trial, Dr. Bettman says. "The trial attorney sees dollar signs. If he (she) can be convinced he won't



collect much, he will drop the case." And most cases *are* dropped or settled before a trial date is reached, he points out. However, if a suit is filed, and you receive a request for your records, Dr. Bettman urges you to:

- get in touch with your insurance company
- find out which of their attorneys will be representing you
- take the records out of the file case yourself
- don't alter them in any way — no matter how terrible they may

seem ("They have companies, now, which can analyze records to see if they have been altered," Dr. Bettman says) and — start a new record of the situation if you're still seeing the patient ("Don't laugh, it happens," he says).

Good records — "Remember, records can go into the jury room — testimony can't," says Dr. Bettman. Therefore, records should be simple ("Don't put in anything that is extraneous,") and make sure you understand *everything* you have put into your records.

"You will be asked to explain, under oath, every symbol you use." Your records should state that you did something, why that something was done, and that your records were written *at that time*. "And don't put notes in your financial records," he advises.

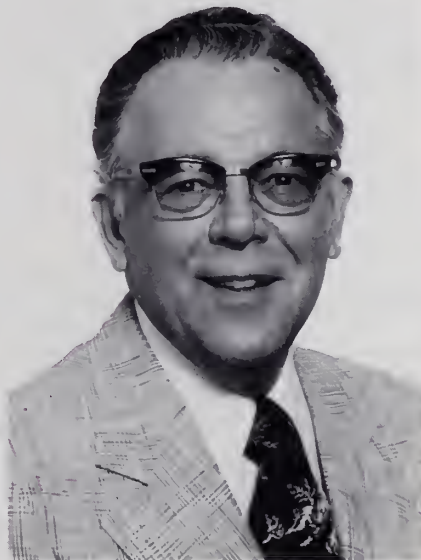
Giving deposition — "Depositions are the most important part of the process," says Dr. Bettman. "They lay the basis for the case and determine whether or not the case will go to trial." Depositions give the opposing attorney an opportunity to pick up information on the case, but it also allows him or her to see how you will act as a witness and how you compare with his or her experts. This is also where he or she lays the groundwork to confuse you, says Dr. Bettman.

"If he (she) can get you to contradict yourself, you lose credibility." What to remember then? Dr. Bettman makes the following suggestions:

- answer every question truthfully.
- never volunteer anything ("Even if it's good for your side, you're allowing the other side an opportunity to prepare a defense.")
- don't read books or literature on the subject beforehand. Although you may want something in the literature introduced, the opposing side may find something in the same book you *don't* want introduced.
- don't discuss the case with a colleague.

On the witness seat — Take your time. Pay attention to the question, and wait for *all* of the questions to be asked before answering. "If it's a compound question, however, break it up and answer it in parts," suggests Dr. Bettman. He also urges physicians to get a copy of the deposition and read it — at least four times — before taking the stand — "so you don't contradict yourself," he explains. "After all, chance favors the prepared mind." — *Karen S. Edwards*

Clarke named to AMA Council of Judicial, Ethical Affairs



Oscar Clarke, MD, Gallipolis, was recently named to the American Medical Association's Council of Judicial and Ethical Affairs. Dr. Clarke will resign from his position as Chairman of the Ohio Delegation to the AMA, and the



post will be assumed by Theodore Castele, MD, Cleveland. (Watch next month's OHIO Medicine for an article on Dr. Clarke and the role of the AMA Council of Judicial and Ethical Affairs.)

A boost for Ohio's hearing impaired

It shouldn't be referred to as a hearing *aid*, says Kenneth M. Alperin, MD, describing an innovation that may enhance the hearing of a select group of individuals.

This smaller-than-dime-size ear implant is more appropriately described as a hearing *device*, explains Dr. Alperin, an ear, nose and throat specialist from Willoughby.

The Zomed Audiant bone-conducting hearing device — as it was christened by its Oklahoma inventor — consists of two parts. One piece, a small magnet attached to a screw, is surgically implanted behind the ear and is attached to the skull with the screw. The other part is an electronic component, also attached to a magnet, that is

placed on the outside of the body behind the earlobe.

The two separate parts of the hearing device are held together by the attraction of the two magnets through the skin. When sound is amplified through the electronic component, the magnets vibrate, conducting sound into the inner ear, Dr. Alperin explains.

It should be made clear, he emphasizes, that this hearing device is applicable only for individuals with specific types of hearing loss, such as those caused by chronic draining, chronic infection or surgical complication.

In these situations, an individual may have a normal inner ear, but the anatomy of the ear canal prevents the sound vibrations from reaching the inner ear, he adds.

continued on next page

Hearing impaired . . .

continued

The number of individuals with these types of conductive hearing losses is limited, Dr. Alperin points out. Less than 10% of the hearing impaired population fit the criteria for the Zomed.

Even so, for those individuals who do fit the bill, the hearing implant is "excellent and works better than a standard hearing aid for this type of hearing impairment," he says.

Because it is appropriate for such a specific population, the Zomed device is not going to edge out the standard hearing aid in the marketplace, he notes.

For those individuals who fit the bill, the hearing implant is excellent.

Dr. Alperin recently attended an Oklahoma-based training class to master the intricacies of implanting the device. A small number of other Ohio physicians have also attended these classes, he adds.

Although he has not yet used the Zomed in treating any of his patients, the implants and accompanying preparations are ready to be put to use — an eventuality he looks forward to.

The hearing device is available in other doctors' offices throughout the U.S. By the sound of things, Ohio is not far behind. — *Deborah Athy*

Predicting dangerousness: a shot in the dark

One of the most dangerous words in a psychiatrist's vocabulary is "dangerousness," according to Robert L. Sadoff, MD, a clinical professor of psychiatry at the University of Pennsylvania in Philadelphia.

Roughly defined, dangerousness is "a sudden change in the behavior of the patient to make him a clear and present danger to himself or others," says Dr. Sadoff, a speaker at the Ohio Psychiatric Association Meeting held recently in Cincinnati.

Psychiatrists traditionally have used this term to describe the status of volatile patients. "Now we are seen as experts in predicting dangerousness."

Lessard vs. Schmidt (Wisconsin) marked the turning point in which dangerousness was established as a prerequisite for involuntary commitment of a patient to a hospital. Psychiatrists are now being held to a standard of predicting dangerousness by the Supreme Court, Dr. Sadoff continues.

This case made waves in virtually every state regarding involuntary commitment legislation. Most courts now demand a determination of dangerousness to self or others for involuntary commitment, rather than a determination of mental illness, he says.

The view that psychiatrists or other physicians can predict the

course of human nature is somewhat like asking them to walk a tight wire without a protective net, he suggests.

Because a determination such as this is so precarious, Dr. Sadoff advises psychiatrists to "let the black robe protect the white coat." That is, if you are unsure about a patient's mental stability, defer the decision of commitment to a judge.

A judge might not possess any medical superiority, but he or she does have immunity and will make a decision based on hearing both sides of the case, he points out.

If you do go to court, don't use the word "dangerousness," Dr. Sadoff advises. Give a clinical vignette of the patient's condition without using this key word.

"It's very difficult to make a decision about whether to discharge a patient, to know whether a person will become dangerous again or if the community is safe," he says. There are some obvious things you can do — review the patient's history and records, for example — but essentially you take an educated guess.

"I'm not going to take a risk," Dr. Sadoff concludes. "We've gone so far (in making these determinations), but we can go back. We treat the person and the illness, not the dangerousness. Predicting dangerousness is really beyond our expertise." — *Deborah Athy*



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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

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The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

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1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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PICO reports third quarter net income increase

Physicians Insurance Company of Ohio recorded consolidated net income of \$1.01 million, or \$.33 per share, for the three months ended September 30, 1987, up 17.5 percent from \$861,996, or \$.28 per share for the same period last year.

For the first nine months of this year, PICO's consolidated net income was \$364,886, or \$.12 per share, compared with \$2.2 million or \$.70 per share for the first three quarters of 1986.

Joseph K. Gilmore, president and chief executive officer, said PICO's third quarter profitability reflects emphasis on appropriate rate levels and quality underwriting programs for all insurance lines.

Gilmore noted that nine months results reflect a \$1.1 million second quarter loss caused by a special addition to loss reserves. The addition of \$8.1 million, which was partially offset by two non-recurring transactions, was made because of an Ohio Supreme Court decision that has in effect removed Ohio's statute of limitations on the filing of medical malpractice claims.

At September 30, 1987, PICO's total direct loss reserves were \$104 million, up 27.5 percent from one year earlier.

Gilmore said: "PICO's reserves and rate levels place the company in a strong fiscal position. No further special additions to reserves because of the unexpected Ohio Supreme Court decision are anticipated."

For the first nine months of this year, premiums written direct by PICO totaled \$55 million, compared with \$65.1 million for the same period last year. Gilmore

PICO FINANCIAL HIGHLIGHTS				
For nine months ended	Three months ended		Nine months ended	
	Sept. 30, 1987	Sept. 30, 1986	Sept. 30, 1987	Sept. 30, 1986
Premiums Written Direct:				
Medical Professional Liability	\$22,030,841	\$24,319,018	\$36,520,910	\$45,897,390
Other Property and Casualty	4,301,338	4,341,815	12,284,651	12,062,669
Life Insurance and Annuities	1,846,108	2,256,885	6,199,076	7,096,083
Total	\$28,178,287	\$30,917,718	\$55,004,637	\$65,056,142
Net Investment Income	3,192,190	2,204,927	8,896,209	6,791,640
Non-Insurance Revenues	1,799,676	2,960,262	5,265,383	5,662,455
Total Operating Revenues	\$33,170,153	\$36,082,907	\$69,166,229	\$77,510,237
Net Income	\$ 1,013,155	\$ 861,996	\$ 364,886	\$ 2,153,194
Per Share	\$0.33	\$0.28	\$0.12	\$0.70
Average Shares Outstanding	3,079,561	3,080,714	3,079,561	3,080,714
At September 30	1987		1986	
Shareholders' Equity	\$ 27,952,302		\$ 26,637,526	
Per Share	\$9.08		\$8.65	
Property and Casualty				
Claims Reserves Direct	103,893,372		81,471,343	
Unearned Premiums	39,327,330		32,490,196	
Life Subsidiary Reserves				
Fund Accumulations	26,752,056		23,409,322	
Assets	\$214,415,145		\$181,889,898	

attributed the decline principally to the transfer of approximately \$9 million in medical professional liability business volume to Physicians Insurance Company of Wisconsin, a new company in which PICO shares ownership with the State Medical Society of Wisconsin and Wisconsin physician-shareholders, and for which PICO provides management services on a fee basis.

PICO's total operating revenues for the first nine months were \$69.2 million, compared with \$77.5 million last year.

For the third quarter, premiums

written direct were \$28.2 million, compared with \$30.9 million. Total revenues were \$33.2 million, compared with \$36.1 million.

At September 30, 1987, PICO's consolidated total assets were \$214.4 million, up 17.8 percent from one year previous. Shareholders' equity (capital and surplus) was \$28 million, or \$9.08 per share, up from \$26.6 million, or \$8.65 per share one year ago.

Gilmore said PICO expects to conclude 1987 with an operating profit, and that current upward trends are expected to continue during 1988.



Agency Reference

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Rural Doctors: Need Outweighs Supply

By Mary Jo Lane

Blanche family physician Kevin Malloy, MD, knew from the start that rural medical practice was not the easiest choice for a new doctor. What he didn't anticipate was how difficult it would be to find a partner to share the long hours and a life that "private" doesn't begin to describe.

Georgetown native Jeff Donohoo, MD, never thought about practicing medicine anywhere but Brown County. But when his father retired from practice early this year, the young doctor decided that unless he found a partner, he might be forced to move away from the people who had encouraged his career.

His father John, who practiced alone in Brown County for most of 36 years, says, "I think the day of the solo rural practitioner is gone."

In many communities in rural southwestern Ohio, finding and keeping doctors concerns young families, senior citizens and civic leaders. The need is usually greatest for primary care physicians.

Rural areas throughout the United States are home to only 17 percent of the nation's doctors. But while experts continue to predict an oversupply of doctors, many rural communities must rely on the few doctors they already have — and hope they won't leave, retire or die. Recruiting and replacement can be next to impossible.

"There's a lot of talk about a doctor surplus . . . but I don't see busloads of doctors coming out here to practice."

"There's a lot of talk about a doctor surplus," says David Ferrell, administrator at Brown County General Hospital, "but I don't see busloads of doctors coming out here to practice."

A simpler lifestyle, friendly people, and natural scenic beauty

are some of the best attributes Adams, Brown, Clermont, Highland and Clinton counties have to offer. But for physicians looking for a secure practice, the disadvantages of country living and practice sometimes outweigh the good.

Fewer doctors in an area means that each physician must carry a heavy load. Often that means being available to patients — "on call" — 24 hours a day, seven days a week. That stress on personal and family life can cause the most dedicated doctor to question his or her vocation.

Uncertainty about getting paid for services can make financial survival tough. For Medicare patients, the government pays rural physicians 30 to 50 percent less for the same services than it pays their city counterparts. And in southern Ohio counties, where the unemployment rate reaches as high as 17 percent, doctors want to provide the care their patients need while they wonder how they'll be paid. In addition, rural doctors must consider the cost of malpractice insurance, which is skyrocketing across the country.



Dr. Kevin Malloy actively searched for a partner to share his Blanchester practice for nearly a year, with no success. The demands of solo practice on himself and his family became overwhelming. In May, he decided to leave Blanchester for a more secure practice in Dayton, Ohio.

"The phone started ringing the minute I got home with patients calling," he explains. "The thing that discouraged me the most about waiting for a partner was when my three-year-old asked if he could make an appointment to come visit me in the office. I don't want my kids to grow up resenting the fact that I was a doctor and didn't spend enough time with them. Some of the pressures people put you under are legitimate; some aren't. But you begin to resent those pressures when you're alone."

He cites another barrier to rural physician recruitment: the long distances to hospitals and specialists. "We're training all doctors in the city, so they're used to having everything they need for treatment close by," explains Dr. Malloy, whose practice was 17 long miles from Clinton Memorial Hospital. "We're talking about a level of comfort that many young doctors don't have. New doctors need to be able to trust themselves, that they can handle what comes up — but it's safer for them in the city."

Dr. Malloy came to Blanchester from his residency at Miami Valley Hospital in Dayton. Both town citizens and Clinton Memorial Hospital had been searching for a number of years for a full-time, permanent physician. They found Dr. Malloy through the federally-sponsored National Health Service Corps (NHSC).

The Corps was established by Congress in the early 1970s to

bring doctors and other health-care professionals to both rural and urban areas that need physicians. For medical students, the NHSC pays tuition and a monthly living stipend in exchange for medical service after a doctor completes medical school and residency.

When the time comes for NHSC physicians to repay their debt and go into practice, they are placed at sites throughout the country that need doctors. The sites, designated by the government, usually are either located in remote areas with few physicians, or located where there is a high concentration of financially needy patients. NHSC physicians are required to work at the site for time equal to the number of years of schooling the Corps financed.

Kevin Malloy completed his three-year NHSC obligation in August 1986. "I had no intention of remaining a solo practitioner," he says. "It's just not practical." Although the Blanchester area still is eligible to receive a Corps physician, he has little hope that will happen.

There's good reason for his skepticism. The National Health Service Corps is being phased out of existence in its current form, the victim of federal budget cuts and Reagan administration opposition. By 1990, only 200-300 new physicians will be available for placement in the country's doctor shortage areas. Sixteen hundred young physicians were placed this year.

During the past 11 years, parts of all of Adams, Brown, Clermont and Highland counties have qualified for placement of NHSC doctors. The placement effort is coordinated through the Southern Ohio Health Services Network (SOHSN), a private, not-for-profit organization governed by a community board.

Dr. Jeff Donohoo was facing a dilemma similar to Dr. Malloy's in late 1986. He knew his father was about to retire from their practice, and his search for a partner had proven futile. After much consideration, he approached the Network as a possible solution for himself and his patients. "They had resources to offer that I couldn't provide," Dr. Donohoo says. "The possibility was very real that if I couldn't get help, I would have seriously considered moving from Brown County." The young Georgetown physician decided to join SOHSN in January 1987.

Doctors are free to leave the area for a new practice after they complete their Corps commitment. Communities, hospitals and the Network encourage physicians to stay on past their required service time; the success of that effort depends on individual physicians. One thing seems clear: with the severe reduction of the Corps, the pool of potential long-term doctors will diminish.

"Eliminating the NHSC will be a real blow to providing health care in rural areas," says Congressman Bill Gradison (R., Ohio), ranking member of the House Ways and Means Health subcommittee. "I seriously doubt that Congress will stand for a total cut of the Corps." National health administrators are lobbying for alternative programs to ensure that the country's most severe health manpower needs are met. In the meantime, the problem of finding doctors for rural areas in southern Ohio remains.

One young family physician returned to his native Brown County in 1980 with a single goal: to create a model of community-supported, local medical care. Of his goal, Walter Ferris, MD, says, "I started out with an idealistic dream that was killed. The whole

situation is too complex. The resources just aren't available locally."

Although he had a National Health Services Corps obligation to fulfill, Dr. Ferris says, "I came to Mt. Orab anti-government. I wanted to show that this community could support a doctor locally, without federal support." But the financial realities of practice in a county with a poverty rate of 22.8 percent (the state average in 1986 was 14.2 percent) hit hard.

"I struggled for years," Dr. Ferris says. "I had some creative ways to help patients — they could work off their bills and

"Poorer patients require more services than higher income patients. They have more doctor visits . . . due to their living situation and the stress (it) creates."

discount their debt. But then I found out I couldn't do that because of the labor laws. And I was seeing my patients lose jobs and become part of the poverty group." At the same time, a change in the way doctors are paid by insurance companies and the government was taking effect nationwide, forcing physicians to reevaluate how they give care and how they charge for it.

A partnership with another physician ended after two years. "There was not a strong enough financial base to support him. I don't blame him for leaving," Dr.

Ferris says. But efforts to recruit a new partner failed.

"I had plenty of patients. But the charges in payment, high overhead, and poverty were too much — yet I didn't want to restrict care," he explains. "The only thing I thought would work in Mt. Orab was a network-type arrangement." Dr. Ferris and his staff joined the Southern Ohio Health Services Network in July 1985.

Patients with low or no income present a dilemma for rural physicians struggling to make ends meet. "Poorer patients require more services than higher income patients," explains Dr. Ferris. "They have more doctor visits and more illness, due to their living situation and the stress the situation creates. As a doctor, you need more time, effort and money to provide them with good care — but it's not there." He points out that small communities searching for a doctor often see opportunity, but overlook the poverty and the effect it can have on a practice.

Dr. Ferris believes that a joint local and government-sponsored effort is the solution to helping ensure that rural residents have access to quality medical care, regardless of their ability to pay. "Local people and communities just don't have the resources to meet the need. The government will have to help, although that support may be in a different form than we have now," he says.

For personal and family reasons, Dr. Ferris and his family left Brown County in August. He is now working for Community Health Plan, a health maintenance organization, in rural New York state.

Caring for indigent patients also concerns Christopher Haas, MD, a family physician in Mt. Orab. "I worry about government funds drying up. What will happen to



the poor patients? When the funds are gone, will sliding fee arrangements go first?"

Despite the difficulties of rural practice, Dr. Haas prefers country life and practice to the city. "I started in rural medicine because I was raised on a farm in northern Ohio, and didn't want to live in the city," he says. After his training, Dr. Haas practiced in eastern Kentucky for four and a half years, in an area more remote than southwestern Ohio. "I'm into folk traditions and play the banjo. There are still a lot of people picking music down there," he says.

For family reasons, Dr. Haas joined the Mt. Orab practice two years ago, and moved his family to Sardinia. "I'm interested in doing a wide variety of things in my practice, and in a rural practice, you end up doing more," he says. "There are no specialists next door, so you end up taking care of things out of necessity."

Tim McKinley, MD, a Sardinia family physician, believes, "There's no better place than a rural area for a true family physician. I like the variety of problems I see. I like seeing kids, adults and the elderly — all are very appealing," he says. "I like the completeness of dealing with both physical and mental problems."

Like Dr. Donohoo, Dr. McKinley is a Brown County native who came home to practice medicine. He was born and raised in New Hope, and grew up on a 200-acre farm. After medical school and residency at the University of Cincinnati, he joined the Sardinia Medical Clinic as its third partner in 1986.

"Since I grew up here, I could easily identify with people living in a rural environment," he says. "For example, if you're going to treat a farmer with a condition that needs rest, you know it's

impossible for him to rest. You can't be a strict 'by the book' physician. So you learn to adapt your practice style to the population you serve.

"This is not the richest area; you're not practicing here to get rich. But I find the people very enjoyable to work with," explains Dr. McKinley. He repeats a theme voiced by the other physicians. "Physicians in rural areas are held in higher esteem than city doctors, because there are fewer doctors and patients identify with them."

Dr. McKinley concedes the difficulty in recruiting doctors to the country, even though their presence and services are valued. "It takes a lot to draw doctors to this kind of area," he says. "They don't understand the benefits of country living. It's difficult to attract doctors to a rural area if they haven't grown up used to this lifestyle."

His opinion is confirmed by much research. Studies of medical students and residents have concluded that the young doctors most likely to choose rural practice for a career are those who came from a rural area and selected the specialty of family practice. Using this information, some medical schools are attempting to combat the rural physician shortage by holding admissions slots for rural applicants, then strongly encouraging students to consider family practice as a career option.

Back in 1951, when John Donohoo, MD, went into practice as a general practitioner, training was shorter and practice was simpler. After medical school, Dr. Donohoo spent one year in an internship at Cincinnati General Hospital (now University Hospital) before going into practice. Today, medical schools train family physicians in place of general practitioners, and require three years of residency before practice.

Dr. Donohoo has seen the effect of the change.

"Medicine is definitely better now; younger doctors are better trained. Patients are getting a different kind of care," he says. "Patients' attitudes have changed, too. They want immediate results; they don't want to wait. That puts more pressure on the doctors."

He has seen a shift in the doctor-patient relationship. "In the 1950s, doctors were held in higher esteem than now. Physicians played a bigger part in families then, mainly because of house calls. They were not only the doctor, but also minister, financial adviser and lawyer."

What has caused the change? "One big factor is liability and malpractice. When I started, malpractice was unheard of. That's one reason I quit making house calls. If you didn't do something the patient needed in the home, you could be sued. You'd be asked, 'Why didn't you take the patient to the hospital?' Physicians have to be more on guard today."

Another major factor is the government's pervasive presence in the practice of medicine, something unheard of until the 1960s.

"In the 1950s, you could do a week's worth of paperwork in an hour. Few people had insurance to cover office calls," Dr. Donohoo recalls. And he has definite opinions regarding government involvement. "Government intervention is a burden. When they can set your fees, I think that's wrong." Dr. Donohoo refers to programs where the government determines how much a doctor will be paid for a visit or procedure, regardless of the doctor's costs. This procedure is used most often for Medicare patient payments.

The issue of government reimbursement to rural physicians

is a critical one now. For Medicare patients, the government pays rural physicians 30 to 50 percent less for the same services than it pays their city counterparts. When setting payment rates, the government based them on the historical charges of rural doctors. But that comparison was deceptive.

"The charges of rural physicians are lower, but their costs aren't," explains Robert Van Hook, executive director of the National Rural Health Association. "To make up the difference between charges and costs, rural doctors see 20 percent more patients than city physicians and practice longer hours. But they can't keep this up. We're seeing changing practice

"To make up the difference between charges and costs, rural doctors see 20 percent more patients than city physicians and practice longer hours."

patterns with younger physicians, who spend more time with patients. As a result, we can't expect the same kind of productivity we've seen from rural doctors in the past. The payment system is discouraging rural practice."

Though many rural hospitals also are fighting hard for survival, having good hospital care nearby is key to attracting and keeping rural doctors. Says Sardinia's Dr. Tim McKinley, "It's an advantage having a hospital here in Brown County where we can take care of 80 percent of the problems we see.

Rural patients are not ones to drive to Cincinnati. They appreciate being seen here."

What does the future hold for rural health care? Says the retired Dr. Donohoo, "The future of rural medicine is not hopeless. There will be changes for the better, and people will have to adjust. Take appointments, for example; I never had them, but my son does now, and patients are adjusting."

Dr. Kevin Malloy believes that forming partnerships of rural physicians holds the most practical solution to keeping doctors.

"Doctors need to get together in groups to arrange time off for educational seminars and vacations; perhaps they could even share an office manager," says the former Blanchester physician. "That way, they could share costs and patient load. I strongly believe that rural doctors need to be in a group practice to survive."

Says Dr. Walter Ferris, "There will continue to be a great need for doctors in rural areas. This is an ideal place for family physicians to practice. You can personally have an impact on the overall health care for the county, and that's very satisfying. We just need to overcome the economic and lifestyle problems."

Mary Jo Lane is Director of Communications, Southern Ohio Health Services Network, Cincinnati.

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CONTRAINDICATIONS

Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

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In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring. In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class. Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

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Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

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C I B A

Cancer:

A Reawakening Interest?

By Karen S. Edwards

In 1984, cancer was “hot.” It was a subject that held both public and professional interest, and a topic that generated more than its share of organized groups in the state. For example, there was the Ohio Cancer Coordinating Committee, a group formed by noted cancer specialist Arthur James, MD. Then came the Consortium for Cancer Control in Ohio . . . the Comprehensive Cancer Center . . . and the Ohio State Medical Association’s own Committee on Cancer.

The next year, however, a new, deadly disease began to garner attention. Suddenly, cancer was no longer “hot” — AIDS was — and public (and, to a lesser extent, professional) interest in cancer began to waver. As funding began to dry up, many of the cancer groups dissolved, OSMA’s Committee on Cancer was put on inactive status, and despite remarkable advances in both treating and screening for all types of cancer, the subject began to be pushed onto back pages and back shelves, in favor of material on

Once again, cancer has become a newsworthy issue . . . and, once again, professionals are tackling the subject — not through state-supported organizations this time, but through their professional associations.

the acquired immunodeficiency syndrome — the new “media darling.”

Then, last year, the pendulum began to swing again. Cancer columns began to appear in local papers . . . cancer screening clinics became more plentiful (and noticeable) . . . and First Lady Nancy Reagan developed breast cancer, bringing that particular problem to national attention.

So what goes around, comes around. Once again, cancer has become a newsworthy issue — a timely topic latched onto by a newly-interested public, and devoured by a fickle media. And, once again, professionals are tackling the subject — not through state-supported organizations this time (the money still isn't there), but through their professional associations, like the OSMA.

In fact, one of the first official acts performed by OSMA President D. Ross Irons, MD when he took office in May was to reactivate the dormant Committee on Cancer. Charles D. Cobau, MD, a Toledo oncologist, and Jerome J. Stanislaw, a surgeon from Warren, were appointed co-chairmen, and the committee was charged to “provide leadership, as well as an arena for developing dialogue on improved treatments.”

President Irons also expressed concern about the “entrepreneurial types of cancer centers” (free-standing, independent screening facilities) that have begun to appear in increasing numbers around the state, and he asked the

committee to try to ensure that all such centers are under physician direction.

Almost immediately, a Task Force on Cancer Screening was formed with Columbus oncologist John Minton, MD, as its head, and the issue was given close scrutiny (for details of their report, see “Cancer . . . a problem too long ignored?” in the December, 1987 issue of *OHIO Medicine*.)

But the committee has no intention of stopping there. They have other issues to study, other problems to address.

“We would also like to increase the physician's awareness of the importance of early cancer screening,” says Committee Chairman Charles Cobau, MD (his co-chairman Jerome Stanislaw, MD was unavailable for comment at the time this article was prepared).

As Dr. Cobau puts it, physicians are familiar with the importance of doing cancer screening in their offices — “but we want to increase their interest in doing so. Naturally, the earlier cancer is detected, the less cancer mortality there would be,” he says.

He is also hoping that the committee can provide the cancer information service with an updated physician-referral list — “something the OSMA apparently did several years ago, but that list is now outdated.”

However, “It's a sensitive list to put together,” Dr. Cobau admits. Those doctors who, for some

reason or other, are not listed as referrals are “apt to feel discriminated against,” he says.

“Still, the Cancer Information Service needs this information. Callers continually ask them to provide names of cancer specialists for consideration.”

However, the committee's principle purpose this year, Dr. Cobau emphasizes, is to establish some sort of standard of care — the “gold standard” as Dr. Irons puts it — for the free-standing diagnostic centers in the state.

“And especially for the breast cancer screening centers,” Dr. Cobau notes. “If we can accomplish this, it will be a very major step.” He adds that the committee is hoping to have some policy on these centers established in time to be presented in a resolution to the House of Delegates at its Annual Meeting this coming May.

Yet, as ambitious as all of this sounds, William A. Newton, MD, a Columbus oncologist who is a current member of the OSMA Cancer Committee (and its chairman during its former active period) is realistic about the committee's agenda. “The committee is purely an advisory committee, made up of experts in the field who meet to discuss cancer-related issues of concern to physicians. It is not an action committee, geared to set up programs,” he says.

Without the kind of clout that comes with funding, Dr. Newton recognizes the committee's limitations. However, there are

many things Dr. Newton would like to see the committee accomplish.

For example, he says he would like to see the committee place its emphasis on the "state cancer plan" that comes out of the well-organized (and funded) Comprehensive Cancer Center.

"The state now has a plan to reduce the mortality of cancer," he says, but the plan is presently in limbo — a victim of politics, he says.

Also fallen by the wayside is a cancer incidence reporting system. Still Dr. Cobau is not certain that such registries need to be reinstituted.

"I realize that arguing against a cancer incidence reporting system is like arguing against apple pie and motherhood," he admits, "and when you hear the system explained, well, it sounds terrific."

Rarely, however, does anyone enter into a discussion of the immense costs it takes to collect and update the data collected by these systems, he points out.

"I'd guess they would cost somewhere around \$1 to \$2 million a year," says Dr. Cobau, "and I know of no constituency willing to spend that kind of money."

Besides, he points out, if that kind of money is going to be spent, it needs to be put to good use — and therein lies another rub.

"No one is exactly sure how to put this data to good use," he says.

Instead, Dr. Cobau would like to see the committee encourage more hospitals to have their cancer programs accredited by the American College of Surgeons — a suggestion Dr. Newton is also quick to endorse.

"I've never been in favor of a state-controlled cancer registry," says Dr. Newton. "A state registry can be a very costly item, as was proven (years ago) by the state of Connecticut."

And the early Ohio Cancer Coordinating Committee, of which Dr. Newton was a member, did at one time attempt to solve the problem by obtaining a federal grant to train to set up tumor registries in hospitals.

"At that time, fewer than 20 hospitals had accredited tumor registries," he points out — and out of a few hundred hospitals across the state, that amounted to only about 10 percent.

Now, Dr. Cobau estimates that closer to 100 hospitals have cancer programs accredited by the ACS, and, therefore, approved registries.

"Obviously, for those hospitals that see only a few cancer patients a year, it is hardly worth the formality of going through the accreditation process — but there are hospitals out there that see a significant number of cancer patients, and their programs are still not accredited. Those are the ones we would like to reach," he says.

Of course, one of the advantages of accredited programs is the tumor registries that collect data on the cancer patients who have been admitted to those hospitals. It would be easy enough, says Dr. Cobau, to set up a central collection agency to tabulate this data. In essence, then, a cancer-incidence reporting system *could* be had fairly readily — and without the necessarily high costs.

But cancer incidence reporting is not the doctor's only concern. Projects that had been assumed by earlier cancer groups — and abandoned at their demise — also need attention, says Dr. Newton.

The Cancer Consortium, for example, was set up to ensure the delivery of state-of-the-art treatment throughout Ohio . . . "and this is presently not being done," he says.

Costs, as well as a lack of knowledge about certain treatments (and where to go to obtain them) are a few of the

reasons these problems exist — and it remains an area that merits concern, says Dr. Newton.

So, too, does environmental control.

"Some cancers could be under better control if the industrial element and certain environmental conditions were taken into consideration" — presently, they are not, he says.

"Also, there is the information system. People don't know what to do with their cancer," Dr. Newton continues.

And while he admits that the information system is improving, "it's not there yet," he claims.

But that's not because information on cancer is being replaced — or even superceded — by information on AIDS.

While Dr. Cobau isn't sure what effect AIDS had on the amount of attention being paid to cancer, he said he believed the National Cancer Institute has, in the past three or four years, made a significant effort to increase the public's interest in cancer, especially with regard to early detection.

Dr. Newton, however, was much more blunt in his considerations.

"AIDS is a small problem in this country — at least in relation to the cancer problem," he says. "One out of four people in this country will die from cancer. That can't be said, yet, about the AIDS problem."

And if the AIDS problem does threaten to become bigger (as most experts now predict), so, too, does the cancer problem, say both doctors.

"Americans are living longer now, and more of the fatal illnesses that used to claim lives — those of a cardiovascular nature, for example — are now being brought into control," says Dr. Newton. "Therefore, I think it is very likely that we will be seeing more cases of cancer, not fewer

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Cancer in Ohio: Keeping Track

By Deborah Athy

So much depends upon the yardsticks by which we measure progress.

Do we measure by survival time, number of cases, research, innovations, statistics, status compared to other states, the drawing board, the future?

Progress is almost always there if we look hard enough. And so, too, is failure. This is certainly true of the medical profession's — and society's — battles with cancer. The second leading cause of death and a battle that's been underway since 400 BC.

First, consider a measure of progress. The National Cancer Institute (NCI) now describes a number of cancers as "curable" — those that are most responsive to therapy in the patient population. These include: several lymphomas, Hodgkin's disease, testicular carcinoma, ovarian carcinoma, Wilms' tumor, childhood leukemia, Ewing's sarcoma, choriocarcinoma, small cell cancer of the lung, and several others.

"Ten years ago we were not able to cure these cancers. Now they are very curable, even in advanced stages," says Orlando J. Martelo, MD, director of Hematology/Oncology at the University of Cincinnati School of Medicine.

But these "curable" cancers comprise only 10% of all cancers. "Unfortunately, the most curable are not the most common," Dr. Martelo continues.

The cancers that are falling short on the yardstick of cures are those that make up the lion's share of cancers — colon, lung, breast, prostate, uterine. "We can get some response, but we cannot establish definitive cures," he says.

According to Thomas A. Nims, MD, a Columbus surgical oncologist and frequent medical writer, "All cancer is curable if found early enough." But there's the catch, many of the most lethal cancers are not found in the early stages.

Detection methods such as mammography, the Pap smear,

guaiac slides and regular examinations have served well, respectively, for breast, cervical and colon cancers. But lung cancer, for example, has no reliable yardstick for early detection.

That's why, when gauging medicine's progress with cancer, we have to remember that each cancer is a different type of disease, suggests Dr. Nims. "At times there's a tendency to use cancer as a wastebasket term, in which everything malignant is thrown in," he says. This may give the impression that no real progress is being made.

Dr. Martelo agrees. "The biggest problem is that people try to lump all the cancers together," he says, which is not only misleading, but may lead to poor treatment compliance on the part of the patients.

If we look at each cancer as separate battles, the scales begin to tip in varying directions. Medicine is winning some major battles

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“At times there is a tendency to use cancer as a wastebasket term, in which everything malignant is thrown in.”

against some of the “curable” cancers mentioned earlier. With other cancers, it’s as if we’re in a stalemated arm wrestling match, holding our own and yet not winning.

And then there’s lung cancer. Consider the figures: an estimated 7,000 deaths in Ohio from lung cancer in 1987. Seven thousand. In California, 13,400 deaths. In Florida, amid the palms and beach umbrella, 9,200. And in New York, 9,700 lung cancer deaths per year.

Lung cancer is one of the most dismal cancers for both men and women, says William D. Inglis, MD, a pulmonary disease specialist at Riverside Hospital in Columbus.

But it hasn’t always been that way. In 1930, lung cancer deaths fell below all other types of cancers except leukemia on the statistical yardstick. So where did we go wrong?

It’s a question that’s been asked and answered before. The ensuing years brought forth an ever-increasing attraction to smoking — as well as an innocence about smoking’s hazards.

As the years passed, Americans continued to indulge in the smoking habit. Even the advertising illustrates a diehard allegiance to tobacco: I’d rather fight than switch . . . or the idea of Marlboro country rising above the mountains like a piece of heaven.

“A generalization is that lung cancer is clearly related to smoking histories,” says Dr. Inglis. “But when the ads say, ‘you’ve come a long way, baby,’ that’s really true,” he says.

Unfortunately, some of those individuals who picked up the smoking habit along the way are now paying a price far dearer than the cost of even a 1980’s pack of cigarettes, or even a year’s supply.

The statistics are beginning to add up for women. Lung cancer recently surpassed breast cancer as the number-one cancer in women, Dr. Inglis points out.

And while lung cancer claims far more lives than any other type of cancer, it is one of the most difficult to detect and treat.

“The diagnosis, even if made early, is generally too late,” leaving patients with nothing better than an average-to-poor diagnosis, he continues.

And the flicker of hope associated with sputum examinations — analyzing the fluid in the lungs for cancerous cells — has remained just a flicker. “It’s helpful to detect the disease, but still not early enough to catch lung cancer in a curable stage,” says Dr. Inglis.

That’s not to say there hasn’t been some progress. Some advances have been made in chemotherapy and other treatment. “We’re getting better and better at buying more and more time,” Dr. Inglis sums up.

The fight against lung cancer is, in many ways, a vicious circle and an uphill battle. “Of all the common cancers, lung cancer is the most lethal. It is also the most preventable,” says Dr. Nims.

This cancer may be the easiest to prevent in theory, but in actuality it’s like trying to push a boulder up a hill.

“Many of us are so committed to the fact that lung cancer is

related to smoking that we feel our priorities may be wrong. Why are we wasting time looking for new ways of early detection and treatment? We need to stop people from smoking,” Dr. Inglis emphasizes.

Lung cancer has edged out breast cancer as the top cancer in women, not because there have been major breakthroughs in breast cancer treatment, but because lung cancer continues to gain momentum.

According to American Cancer Society (ACS) estimates, there were approximately 130,000 new breast cancer cases in the U.S. in 1987. Ohio ranked sixth in the number of new cases with 6,600 and fifth in the number of breast cancer deaths with 2,100.

Although there has not been an overall boost in the cure rate, progress has been visible in other areas. “Our ability to detect breast cancer has been greatly enhanced, primarily with mammography,” says R.L. Coith, Sr., MD, director of the Breast Consultation Center at the University of Cincinnati.

Greater public awareness and accessibility to information about cancer signs, self examination, regular exams, mammography, and treatment options have played important roles in the earlier detection of the disease.

“With Betty Ford and Mrs. Rockefeller, breast cancer became a national issue. It has recently been brought up closer to the public again with Nancy Reagan,” Dr. Coith points out. When medical conditions are well-publicized, research often reaps some benefits, he adds.

Women are still fearful when

they come into the office, but now they have more options, according to Dr. Nims.

"We have changed the methods in treating so that women don't have to fear the radical mastectomy. We're doing lesser surgeries with more radiation."

A recent study in the *New England Journal of Medicine* (NEJM) reported that women who choose lump removal over mastectomy live just as long, which suggests that lump removal is appropriate treatment in some cases. While there is a chance of recurrence, there is no evidence that lumpectomy decreases survival time any more than mastectomy does, the article noted.

Recent years have also introduced a shift toward the modified rather than radical mastectomy. But Dr. Nims points out that each woman must make her own decision based on her own set of circumstances and values.

The five-year survival rates for breast cancer have improved from 78% in the 1940s to 90% today. If the cancer is not invasive, these rates approach 100% survival, according to the ACS.

Fast-food restaurants, four-lane highways, drive-through banking — all signs of a society on the go and eating on the run, often with a predominance of high-fat, low-fiber diets. This may help to explain why colon-rectum cancer accounts for the second highest cancer mortality rate in the U.S.

Ohio is sixth in the estimated number of new colon-rectum cancer cases with 7,300 in 1987, falling between Illinois and Texas. Overall there were 145,000 new colon-rectum cancer cases in the U.S., with New York and California topping the lists, according to ACS estimates.

If detected early enough, the five-year survival rates are 86% for colon cancer and 77% for rectal cancer. If the disease

Breast Cancer: Diagnosis and Treatment Information



Ohio Chapter
American College of Surgeons

in cooperation with the
Ohio State
Medical Association

How to tell breast cancer patients what they need to know

In response to House Bill 215, which would require a physician to provide information and explain alternative breast cancer treatments, the Ohio Chapter of the American College of Surgeons (with the help of the OSMA's Department of Communications) have prepared a brochure "Breast Cancer: Diagnosis and Treatment Information" which is currently being distributed to patients in need of such information.

The brochure, originally developed by the OCACS' Socioeconomic committee, then chaired by D. Ross Irons, MD, is currently being revised under the direction of Richard Reiling, MD, and will include an expanded section on radiology. Over 37,000 of the brochures have already been distributed through both OCACS and the OSMA, and the revised edition should be available soon.

In addition to its popularity with physicians, patients and the public, the brochure has also proven to be popular with OSMA leaders and staff who see it as an effective response to mandating this kind of patient education.

"This brochure and the diligent efforts of the Ohio Chapter of the American College of Surgeons," writes the OSMA Department of Legislation in their article "Legislative Predictions" (*OHIO Medicine*, January, '88), "is an excellent example of physicians being proactive on an issue in order to demonstrate to the Ohio General Assembly that there are non-regulatory remedies to perceived problems." Copies of the brochure, they add, have been sent to all state legislators.

Additional copies of the brochure can be ordered for \$8 per 50 by contacting The Ohio Chapter, American College of Surgeons, c/o 600 South High Street, Columbus, Ohio 43215.

“We are more likely to get a handle on curing more cancers by finding them early than we will by finding new means to treat advanced cancers.”

spreads undetected, these numbers drop to 39%, colon, and 31%, rectal cancer.

“In the past, people thought a diagnosis of colon cancer meant they needed a colostomy,” Dr. Nims says. Today only 15% actually need this type of surgery if the disease is identified early enough.

A few facts about other cancers:

- The ACS projects that there will be 96,000 new cases of prostate cancer in 1987. Prostate cancer is the third most common cancer in men, affecting about one in 11. Survival rates have improved in the last 20 years, from 48% to 70%. One Ohio physician recently pointed out that prostate cancer is often overshadowed by breast and cervical cancers in women and by lung and colon cancer overall.
- “One of the most dismal cancers is melanoma, a pigmented cancer of the skin,” according to Dr. Martelo. If localized, the cancer can be removed with surgery. If not, melanoma can become metastatic, in which case there is no effective treatment, he says.
- Oral cancer affects twice as many men as women and has an estimated five-year survival rate of 51%. There were an estimated 30,000 new cases in 1987.
- The mortality rate for uterine/cervical cancers has decreased more than 70% due to Pap smears, according to the ACS. Invasive cervical cancer incidence has decreased, but cancer in situ is on the rise.

“We are more likely to get a handle on curing more cancers by finding them early than we will by finding new means to treat advanced cancers,” says Dr. Nims.

However, there are a variety of means currently being explored in the laboratory that may lead the way for some victories in the battle against cancer. Some of these include:

- Immunotherapy. Interleukin-2 and interferon have been effective in treating some patients in advanced stages of cancer, such as in hairy cell leukemia. This method enhances the body’s immune system to fight disease. “The fact that we have seen some progress may open up some new avenues,” Dr. Martelo points out. A recent article in the *NEJM* emphasizes that immunotherapy is still under study and is not a cure.
- Monoclonal antibodies. This treatment involves fusing cancer cells with normal cells to produce disease-fighting monoclonal antibodies that seek out cancer targets for chemotherapy and radiation therapy.
- Growth factors. “The problem with chemotherapy is that it suppresses bone marrow,” says Dr. Martelo. Recombinant growth stimulating factors (GSFs) can be used to increase the production of white blood cells, platelets and red blood cells in bone marrow, enabling patients to recover more quickly from chemotherapy. This treatment may pave the way for more aggressive chemotherapy, he says.
- High-tech diagnostic imaging

techniques such as Magnetic Resonance Imaging (MRI) and Computerized tomography (CT) have enabled some exploratory surgeries to be reduced.

- Ultrasound is under investigation as a method of early detection in prostate cancer, by scanning the entire prostate during examination.
- Another area of new hope is in lasers, says Dr. Nims. For example, lasers may be effective on hard-to-reach areas that were previously thought to be inoperable, such as cancer of the esophagus.
- Phototropic therapy, in which cells are injected with a light-sensitive substance, is under study. “This treatment is in its infancy, but has great potential, especially for lung cancer, in which cancers are small and can be reached by shining a light into the trachea,” Dr. Nims explains.

“Throughout our society there is an increased awareness of cancer and an increased willingness to seek help when individuals notice body changes and cancer signs,” he says.

But at the same time, the tendency to want to pass the blame is still strong. According to a National Cancer Institute poll, 50% of individuals still believe — as singer Joe Jackson lamented in a 1980s release — that “everything gives you cancer.”

But “everything” is usually an individual’s own baggage — tobacco, diet, alcohol, exposure to the sun. Occupational hazards, viruses and food additives account for only about 7% of all cancers, the ACS reports.

“As people live longer and if

the environment remains uncontrolled, as I believe it is now, cancer incidence may increase as our immune systems wane with age," Dr. Martelo points out.

But one's own surroundings and lifestyle will continue to play a major role in one's health. For example, "with lung cancer, the environment is really the smoker," he adds.

By the year 2000, the National Cancer Institute hopes to decrease the incidence of cancer in the U.S. by 50% — from 180 cases in 100,000 to 80-90 cases in 100,000.

"Lung cancer has really hampered the goal of the NCI and will probably prevent them from realizing this goal," Dr. Martelo concludes.

But he and others are not without hope. "Every day we are seeing advances. One of these new drugs could be the curative agent," he says.

So much depends . . . on the future. OSMA

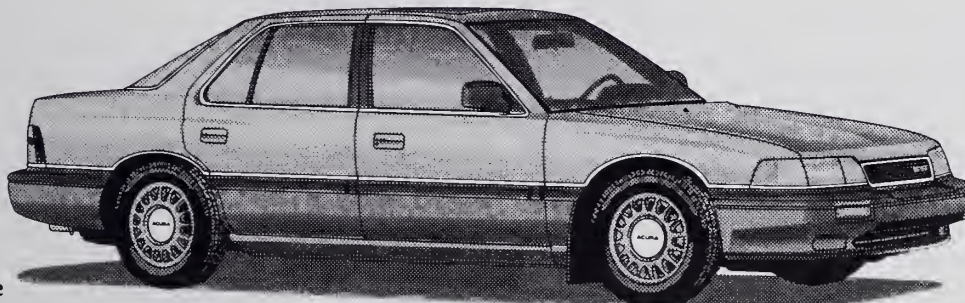
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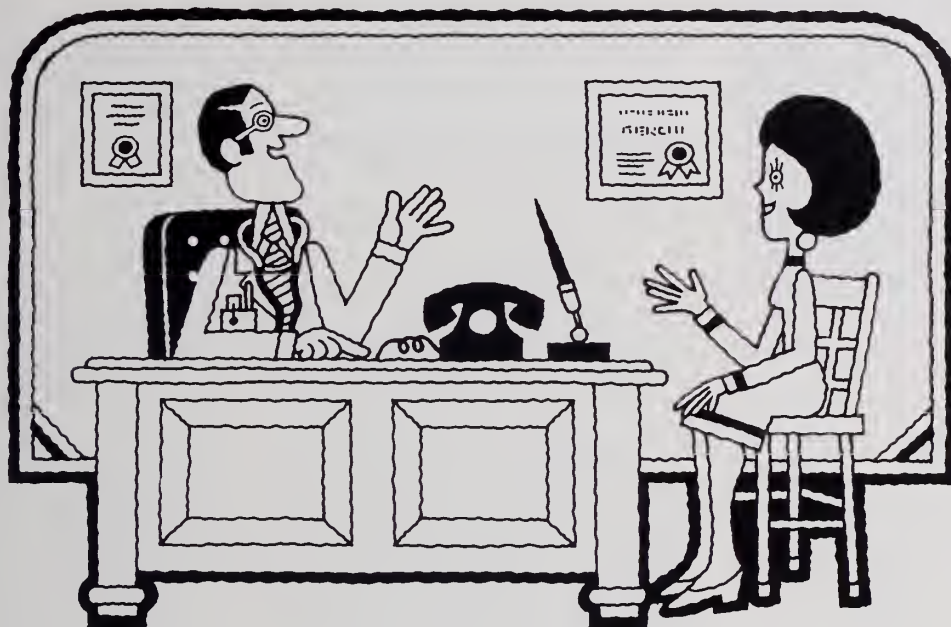
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“Mammography Mania”: Is It Sweeping the State?

By Michelle J. Carlson

Nov. 17, 1987: The *Daily Sentinel-Tribune* in Bowling Green reports that Wood County Hospital has noticed a marked increase in the number of women seeking mammograms.

- Nov. 19, 1987: The *Sun Times Sentinel* in Brunswick devotes nearly a full page to a breast cancer story in which the reporter undergoes a breast exam and mammogram and relates her experience firsthand.

- Dec. 21, 1987: The *Columbus Dispatch* in Columbus reports the local cancer society is encouraging

that mammograms be offered at discount rates so that more women may take advantage of the procedure.

- Dec. 22, 1987: Ironically — but hardly surprising — on the same day this article was prepared, *OHIO Medicine* received an unsolicited manuscript relating physicians' beliefs and practices where mammography is concerned.

The truth is, pick up almost any newspaper, magazine or journal today, and chances are you'll be bombarded by any number of articles about breast cancer, its

prevention, detection and management.

Likewise, breast cancer statistics and guidelines for undergoing breast exams have been published so often, rare is the woman who isn't aware that her chance of getting breast cancer is about one in 10. Many also know that they should receive a baseline mammogram at age 35, one every other year from ages 40 to 49, and one every year after age 50.

While most physicians would agree that informing and updating the public on medical breakthroughs and discoveries is an important priority, others voice concern that the media blitz has produced, in the words of one physician, a “mammography mania.”

“There's a lot of pressure to have a mammogram,” explains John P. Minton, MD, a Columbus oncologist and professor of surgery at Ohio State University Hospitals. “I like to call it ‘mammography mania.’ It's the national thing now.”

Not surprisingly, the media's preoccupation with breast cancer, coupled with women's growing interest in the disease, has prompted a number of breast cancer screening clinics to spring up across the state. Indeed, according to statistics provided by the Ohio State Comprehensive Cancer Center, there are approximately 70 some clinics that provide breast cancer screening and/or imaging services now operating in the state.

But while the proliferation of such clinics is generally viewed as good news — for example, women who previously had limited access to such clinics now have literally dozens to choose from — some physicians are alarmed by the relatively unchecked growth of these facilities, especially of the so-called free-standing clinics.

In fact, this concern was recently brought to the attention

of the OSMA's Task Force on Cancer Screening. The committee, which met last September to discuss the issue, is currently investigating the operations and qualifications of such clinics, and expects to issue its recommendations and guidelines on the subject this June.

According to Dr. Minton, who also acts as the committee's chairman, “We need to establish that these clinics are properly staffed . . . and the equipment they're using is the best.”

“The big concern we have,” he continues, “is that a woman who goes to one of these clinics may be working with a technician or non-certified personnel” instead of a physician or licensed or registered nurse. Unfortunately, he adds, “We think that's the rule, not the exception.”

Harold Hughes Hawkins, MD, director of radiology at Drake Memorial Hospital in Cincinnati, agrees that properly-trained personnel are vital to the success of any breast cancer screening clinic.

“Mammography is very dependent upon a very well-trained, experienced mammographer and the technician actually doing the examinations,” he says.

However, he stresses that when determining competence, equal emphasis must be placed upon the professional's education *and* experience.

By way of example, he says, “If you have a hospital only doing two or so mammographies a week, it's hard to get a radiologist who will be able to read the images accurately.”

In other words, education is a good base from which to start, but the diagnostic radiologist who reads a high number of breast X-rays is likely to be much more proficient at discerning breast cancers from acceptable breast abnormalities.

Dr. Minton agrees, stating simply: “The more you do, the more accurate you become.”

Another point Dr. Minton raises is that the diagnostic radiologist with considerable experience interpreting breast X-rays is less likely to overdiagnose or misread a mammogram film — for example, interpreting a breast abnormality as a cancerous tumor and recommending the surgeon perform a biopsy.

Such overcautious behavior, says Dr. Minton, “takes the radiologist off the hook (for malpractice), but it puts the surgeon *on* the hook” if he or she performs an unnecessary operation.

As for the equipment that screening clinics use, physicians seem to unanimously agree that Dedicated Imaging Units are by far and away the accepted standard.

“If they're not using a Dedicated Unit,” notes Dr. Hawkins, “I wouldn't even bother going to the clinic. To do breast imaging without Dedicated equipment is useless.”

Dr. Minton takes that claim a step further, recommending that prospective patients check with the clinic to ensure that its equipment is not only Dedicated, but is less than two years old. Equipment any older than that, he explains, delivers relatively high doses of radiation, which are unacceptable by today's standards.

Assuming that a clinic has retained the latest Dedicated equipment, there is one more thing to consider — that the equipment is regularly and properly maintained.

“Hopefully, (the clinics) are meeting the requirements,” says Kathleen Gough, medical affairs director of the Franklin County chapter of the American Cancer Society. “To my knowledge, all of the local breast-imaging clinics are reputable.” However, she adds,

“It could be anyone setting (a clinic) up — businessmen, entrepreneurs, physicians — anyone.”

John P. Minton, MD, Columbus



“There’s always that chance that the equipment hasn’t been gauged properly.”

Because there is currently no one group or organization that regulates breast cancer screening clinics, the OSMA’s Task Force is now questioning just *who* is qualified to run these clinics.

Says Dr. Minton, “It could be anyone setting (a clinic) up — businessmen, entrepreneurs, physicians — anyone.”

However, Roland T. Skeel, MD, a Toledo oncologist and a member of the Task Force, isn’t convinced that there are many clinics being run by inexperienced, unqualified, or perhaps money-motivated individuals.

“I’m not aware of anyone setting them up for profit,” he says. “If that were the case, I’d have some philosophical problems with it.”

While Dr. Skeel is not exactly a champion of free-standing clinics, he does concede that they have a certain place in the health-care field. “The reason for them is availability, convenience. Those people doing free-standing mammographies, as long as they have the proper supervision, is fine.”

Furthermore, he says, “I think it’s important that there isn’t a policy that says a person has to go to a hospital and be recommended by a physician.”

While some physicians may have philosophical differences, most are able to agree that:

- Breast cancer screening clinics should use Dedicated Imaging

equipment that is no more than two years old.

- Breast exams should be performed by a licensed physician.
- Breast X-rays should be read by a certified, experienced, diagnostic radiologist.
- The clinic should perform a relatively large number of mammograms, thereby helping to ensure that the radiologist is skilled at reading breast X-ray films.

The physicians also recommend that women not be afraid to ask questions when selecting a clinic.

“I’d call and ask if my films will be read by an experienced radiologist,” says Dr. Minton. “Will my physical be performed by a physician, a practical nurse or a registered nurse?” It is important to determine exactly *who* will be performing *what* procedures, he says, because “Anyone can put on a white coat and a name tag.”

Adds Dr. Hawkins: “If I were directing my wife someplace, for her best chance of getting a good workup, I’d tell her to go somewhere that does a high volume of mammographies, somewhere that uses trained technicians and radiologists experienced in reading mammographies.”

While it is relatively easy to offer suggestions for choosing a breast cancer screening clinic, it is much more difficult to determine if these clinics are offering competent exams.

“There’s not a documented

history of performance” of free-standing clinics, claims Dr. Minton. “There ought to be some basis upon which to regulate these clinics.”

Dr. Skeel, however, is awaiting more information before passing judgment on free-standing clinics. “I think it’s unknown at this point. I think it’s a potential problem . . . (but) I don’t think there’s enough information at hand,” he says.

“What I think ought to be done,” he continues, “is that people need to be aware that there are good (clinics) and bad ones.”

Until June — when the Task Force is expected to issue its recommendations regarding breast cancer screening clinics — the controversy will continue to rage. In the meantime, physicians will simply have to take it upon themselves to guide their patients in selecting the most competent, qualified center in which to undergo breast cancer screening.

Michelle J. Carlson is Editorial Assistant for OHIO Medicine.

QUOTES OF NOTE

On the practice of medicine

“It should be the function of medicine to have people die young as late as possible.”

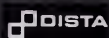
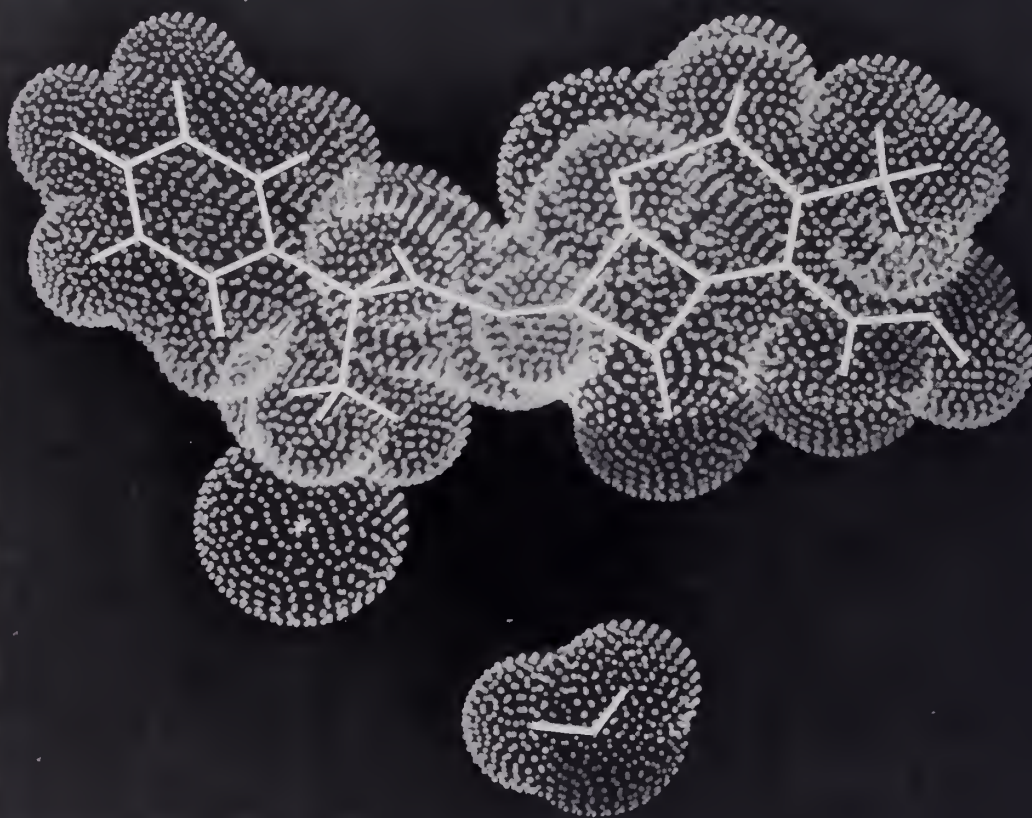
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HIV/Lymphadenopathy-Associated Virus:

Agent Summary Statement

From the Centers for Disease Control

Introduction

In March 1984, CDC and the National Institutes of Health (NIH), in consultation with scientists, physicians, and public health workers in academia, industry and government, published a manual entitled *Biosafety in Microbiological and Biomedical Laboratories* ("biosafety manual").^{*1} The manual describes combinations of standard and special microbiologic practices, safety equipment, and facilities recommended for working with infectious agents in various laboratory settings. The recommendations are advisory and provide a voluntary code of safety practices.

A section of this manual is devoted to a number of specific "agent summary statements" consisting of brief descriptions of documented or anecdotal laboratory-associated infections,

the nature of the laboratory hazards, and recommended precautions to be taken in handling and working with certain infectious agents. Contributors to the manual recognized that new agents would be discovered from time to time and recommended that a summary statement for each new agent be developed and published in the *MMWR*. The summary statement for human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV)[†] follows. All laboratory directors are requested to put a copy of this summary in each of their copies of the biosafety manual and bring it to the attention of laboratory personnel. The recommendations in the summary statement were compiled from published scientific reports and are consistent with the published guidelines for health-care workers.²⁻⁴

Agent Summary Statement: HTLV-III/LAV

As of August 15, 1986, no cases of acquired immunodeficiency syndrome (AIDS) that meet the CDC case definition and can be attributed to an inadvertent laboratory exposure have been reported in laboratory workers.⁵ One laboratory worker⁷ was included among the health-care workers who have had HTLV-III/LAV antibody detected in their serum after sustaining a needlestick injury,^{2,3,6-10} but the

source of the infection could not be established. Persons who are infected with HTLV-III/LAV may be asymptomatic, may have AIDS-related complex, or may manifest symptoms of overt AIDS.¹¹

In 1985, two different reagent production laboratories reported that several laboratory workers may have been inadvertently exposed to an aerosol of concentrated HTLV-III/LAV; one worker was cut by a piece of glass from a broken carboy that contained HTLV-III/LAV-infected cells and culture fluid. None of the potentially exposed persons had shown evidence of seroconversion after six months in one incident and 12 months in the other as a result of these occupational exposures.

Other reports dealing with HTLV-III/LAV infection in health-care personnel, including laboratory workers,^{3,4,6,8-10} indicate that the risk of bloodborne transmission from inadvertent exposure is considerably less for HTLV-III/LAV than for hepatitis B virus infection. These reports illustrate the need for complete evaluation by a physician and serologic testing of each laboratory worker definitely or possibly exposed to HTLV-III/LAV in a laboratory setting. It is recommended that the Public Health Service guidelines for health-care workers be followed in these instances.^{2,3}

*Available from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock #01702300167-1, Price: \$4.00; and from National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161, Stock # PB84-206879, Price: \$6.00.

†The Human Retrovirus Subcommittee of the International Committee on the Taxonomy of Viruses has proposed the name human immunodeficiency virus (HIV) for these viruses (Science 1986; 232:697).

Laboratory Hazards

HTLV-III/LAV has been isolated from blood, semen, saliva, tears, urine, cerebrospinal fluid, brain tissue and cervical secretions and is likely to be present in other body fluids, secretions and tissues of infected humans or experimentally infected nonhuman primates. Percutaneous or parenteral inoculation and direct contact of cuts, scratches, abrasions or mucosal surfaces with suspensions of virus or specimens containing live virus are considered potential routes of infection. Possible transmission of infection via the parenteral route can occur through self-inoculation with needles, broken glass or other sharp objects that contain HTLV-III/LAV. Spillage is a possible means of exposure and infection, especially spills accompanied by spraying or splashing of infected cell cultures, viral concentrates and other infectious materials that may come into direct contact with abraded skin or mucous membranes of the eyes, nose or mouth; however, there are no data documenting or suggesting that transmission of HTLV-III/LAV has occurred in this manner. Ingestion and inhalation have not been documented as modes of transmission of the virus.

Recommended Precautions

1. Biosafety Level (BSL) 2

standards and special practices, containment equipment and facilities as described in the CDC-NIH biosafety manual are recommended for activities involving clinical specimens, body fluids or tissues from humans or laboratory animals that may contain HTLV-III/LAV. *These are the same practices recommended for all clinical specimens.* Emphasis is placed on the following practices, which are included in the manual:¹

- a. Use of syringes, needles and other sharp instruments should be avoided if possible. Used needles and cutting instruments should be discarded into a puncture-resistant container with a lid. Needles should *not* be resheathed, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
- b. Gloves should be worn by all personnel engaged in activities that may involve skin contact with potentially infectious fluids, tissues or cultures and by laboratory workers with dermatitis or other lesions on the hands who may have direct or indirect contact with potentially infectious materials. Handwashing with soap and water should be a routine practice immediately after direct contact with potentially infectious materials and on completion of work, even when gloves are worn.
- c. Generation of aerosols, splashes and spills of potentially infectious materials should be avoided in procedures involving body fluids or tissues, during necropsy of cadavers, and in similar procedures on animals experimentally infected with HTLV-III/LAV. Laboratory workers should use a biological safety cabinet when propagating the virus to further reduce the risk of exposure. Although the major precautions are listed here, the CDC-NIH biosafety manual contains additional related precautions. In all instances, the laboratory director is responsible for assessing the biosafety level to be used.
- d. Human serum from any source that is used as a control or reagent in a test procedure should be handled at BSL 2. Appended to this Agent Summary Statement is a statement (Addendum 1) issued by CDC on the use of all human control or reagent sera shipped to other laboratories. The Food and Drug Administration requires that manufacturers of human serum reagents use a similarly worded statement.
- e. Animal BSL 2 practices, containment equipment, and facilities are recommended for activities involving nonhuman primates experimentally infected with HTLV-III/LAV. Laboratory coats, gowns or uniforms should be worn by laboratory workers, as is customary for other BSL 2 or 3 practices, depending on the nature of the work, concentration of the virus and volume of material being handled. Because many animals bite, and some throw feces, urine or expectorate at humans, animal-care personnel must wear coats, protective gloves, coveralls or uniforms, and face shields as appropriate to protect the skin and mucous membranes of the eyes, nose and mouth from potential exposure to these substances when working with animals likely to manifest such behavior.
2. Activities such as growing research laboratory-scale amounts of HTLV-III/LAV or related viruses or virus-producing cell lines, working with concentrated virus preparations, or conducting procedures that may produce

- droplets or aerosols should be performed in a BSL 2 facility with the additional practices and containment equipment recommended for BSL 3.¹²
3. Activities involving industrial-scale, large-volume or high-concentration production and manipulation of HTLV-III/LAV are to be conducted with BSL 3 requirements.¹²
 4. All laboratory glassware, equipment, disposable materials and wastes suspected or known to contain HTLV-III/LAV must be decontaminated, preferably in an autoclave, before washing, discarding, etc. Incineration of solid wastes may be used as an alternate method of disposal.
 5. There is no evidence that laboratory clothing soiled with materials known or suspected to contain HTLV-III/LAV poses a transmission hazard, and the handling of such clothing is covered under BSL 2 practices. However, to be consistent with BSL 3 recommendations,¹ when laboratory clothing becomes contaminated with HTLV-III/LAV preparations, it should be decontaminated before being laundered or discarded.
 6. Work surfaces should be decontaminated at the end of each day on completion of procedures or when overtly contaminated. Many commonly used chemical disinfectants with such active ingredients as sodium hypochlorite, formaldehyde, glutaraldehyde, or phenols^{4,13-15} can be used to decontaminate laboratory work surfaces; they can also be used to decontaminate some laboratory instruments, specific areas of contaminated laboratory clothing and spills of infectious materials. Prompt decontamination of spills and other overt contamination should be standard practice.
 7. The prudent and recommended approach to handling human serum known or suspected to contain HTLV-III/LAV is to use the same precautions that should be used routinely to prevent transmission of bloodborne infections, including hepatitis B.¹⁶ Available data on the effectiveness of heat to destroy HTLV-III/LAV suspected or known to be present in human serum are at variance because of variations in volume of serum, concentration of the virus, temperature and duration of exposure to heat.^{14,15,17} Similarly, results of chemical analyses or antibody assays may vary when sera are heated before testing according to the analysis or assay being performed.¹⁸⁻²⁰ However, there is agreement that testing heated serum for HTLV-III/LAV antibody by enzyme immunoassays often yields false-positive results.²¹⁻²³
 8. No HTLV-III/LAV vaccine has been developed, and no drugs have been shown to be safe and effective for therapy. As part of an ongoing medical surveillance program for employees, all laboratory workers before being assigned to activities with a high potential for exposure should have a serum sample obtained and stored at -40°C (-40°F) for possible future testing. Subsequent serum samples should be obtained and stored in accordance with laboratory policy or following an inadvertent laboratory exposure involving materials described above. When indicated, these serum specimens should be tested by a qualified laboratory using currently recommended procedures for HTLV-III/LAV antibody. Furthermore, the physician requesting serologic testing of these serum specimens must first obtain informed consent from the laboratory worker and describe the confidentiality safeguards available to protect test results. The laboratory workers whose serum specimens are to be tested should understand how the test results are to be used, the implications of a positive or negative test result, and the limits, if any, of the confidentiality safeguards. An employee whose serum HTLV-III/LAV antibody test is reactive and whose subsequent tests and evaluation confirm the presence of HTLV-III/LAV infection should be counseled to follow the Public Health Service recommendations for preventing transmission.^{24,25}
 9. In addition to HTLV-III/LAV, other primary, as well as opportunistic, pathogenic agents may be present in the body fluids and tissues of persons who are antibody positive or have AIDS-related complex or AIDS. Laboratory workers should follow accepted biosafety practices to ensure maximum protection against inadvertent laboratory infection with agents other than HTLV-III/LAV that may also be present in clinical specimens.
- Reported by Div of Safety, National Institute of Allergy and Infectious Diseases, National Cancer Institute, National Institutes of Health; AIDS Program, Hospital Infections Program, Center for Infectious Diseases, Laboratory Program Office, Office of Biosafety, Office of the Director, CDC.
- ### Addendum
- CDC cautionary notice for all human serum samples used as controls or reagents:
- Warning:** Because no test

method can offer complete assurance that laboratory specimens do not contain HTLV-III/LAV, hepatitis B virus or other infectious agents, this specimen(s) should be handled at the BSL 2 as recommended for any potentially infectious human serum or blood specimen in the CDC-NIH manual, *Biosafety in Microbiological and Biomedical Laboratories*, 1984, pages 11-3.

One or more of the following statements should be included with the above warning statement:

- This specimen is negative for hepatitis B surface antigen (HBsAg).
- This specimen is negative for antibody to HTLV-III/LAV.
- This specimen is positive for hepatitis B surface antigen (HBsAg).
- This specimen is positive for antibody to HTLV-III/LAV.
- This specimen has NOT been tested for hepatitis B surface antigen (HBsAg).
- This specimen has NOT been tested for antibody to HTLV-III/LAV.
- This specimen has been heated at 56 C (133 F) for 30 minutes (which will not inactivate HBsAg but will inactivate HTLV-III/LAV).

REFERENCES

1. Richardson JH, Barkley WE, eds. *Biosafety in microbiological and biomedical laboratories*, 1984. Washington, DC: US Department of Health and Human Services, Public Health Service. HHS publication no. (CDC) 84-8395.
2. CDC. Update: evaluation of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection in health-care personnel — United States. *MMWR* 1985;34:575-8.
3. CDC. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. *MMWR* 1985;34:682-6, 691-5.
4. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. *MMWR* 1982;32:577-80.
5. CDC. Revision of the case definition of acquired immunodeficiency syndrome for national reporting — United States. *MMWR* 1985;34:373-5.
6. Weiss SH, Saxinger WC, Richtman D, et al. HTLV-III infection among health-care workers: association with needlestick injuries. *JAMA* 1985;254:2089-93.
7. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. *Lancet* 1984;ii:1376-7.
8. Henderson DK, Saah AJ, Zak BJ, et al. Risk of nosocomial infection with human T-cell lymphotropic virus type III/lymphadenopathy-associated virus in a large cohort of intensively exposed health-care workers. *Ann Intern Med* 1986;104:644-7.
9. Stricof RL, Morse DL. HTLV-III/LAV seroconversion following a deep, intramuscular needlestick injury [Letter]. *New Engl J Med* 1986;314:1115.
10. McCray E and the Cooperative Needlestick Surveillance Group. Occupational risk of the acquired immunodeficiency syndrome among health-care workers. *N Engl J Med* 1986;314:1127-32.
11. CDC. Classification system for human T-lymphotropic virus type III/lymphadenopathy-associated virus infections. *MMWR* 1986;35:334-9.
12. U.S. Department of Health and Human Services, Public Health Service. *Biosafety guidelines for use of HTLV-III and related viruses*. Federal Register 1984;49:Number 201, 40556.
13. Favero MS. Sterilization, disinfection and antisepsis in the hospital. In: Lennette EH, Balows A, Hausler WJ, Jr, Shadomy HJ, eds. *Manual of clinical microbiology*. Washington, DC: American Society for Microbiology, 1985:129-37.
14. Martin LS, McDougal JS, Loskoski SL. Disinfection and inactivation of the human T lymphotropic virus type III/lymphadenopathy-associated virus. *J Infect Dis* 1985;152:400-3.
15. Resnick L, Veren K, Salahuddin, SZ, Tondreau S, Markham PD. Stability and inactivation of HTLV-III/LAV under clinical and laboratory environments. *JAMA* 1986;255:1887-91.
16. Favero MS, Petersen NJ, Bond WW. Transmission and control of laboratory-acquired hepatitis infection. In: Miller BM, Groschel DHM, Richardson JH, et al., eds. *Laboratory safety: principles and practice*. Washington, DC: American Society for Microbiology, 1986:49-58.
17. Ronalds CJ, Grint PCA, Kangro HD. Disinfection and inactivation of HTLV-III/LAV [Letter]. *J Infect Dis* 1986;153:996.
18. Goldie DJ, McConnell AA, Cooke PR. Heat treatment of whole blood and serum before chemical analysis [Letter]. *Lancet* 1985;i:1161.
19. Lai L, Ball G, Stevens J, Shanson D. Effect of heat treatment of plasma and serum on biochemical indices [Letter]. *Lancet* 1985;i:1457-8.
20. Evans RP, Shanson DC. Effect of heat on serological tests for hepatitis B and syphilis and on aminoglycoside assays [Letter]. *Lancet* 1985;i:1458.
21. Van den Akker R, Hekker AC, Osterhaus ADME. Heat inactivation of serum may interfere with HTLV-III/LAV serology [Letter]. *Lancet* 1985;ii:672.
22. Mortimer PP, Parry JV, Mortimer JY. Which anti-HTLV III/LAV assays for screening and confirmatory testing? *Lancet* 1985;ii:873-7.
23. Jungkind DL, DiRenzo SA, Young SJ. Effect of using heat-inactivated serum with the Abbott human T-cell lymphotropic virus type III antibody test. *J Clin Microbiol* 1986;23:381-2.

24. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983;32:101-3.
25. CDC. Additional recommendations to reduce sexual and drug abuse-related transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1986;35:152-5.

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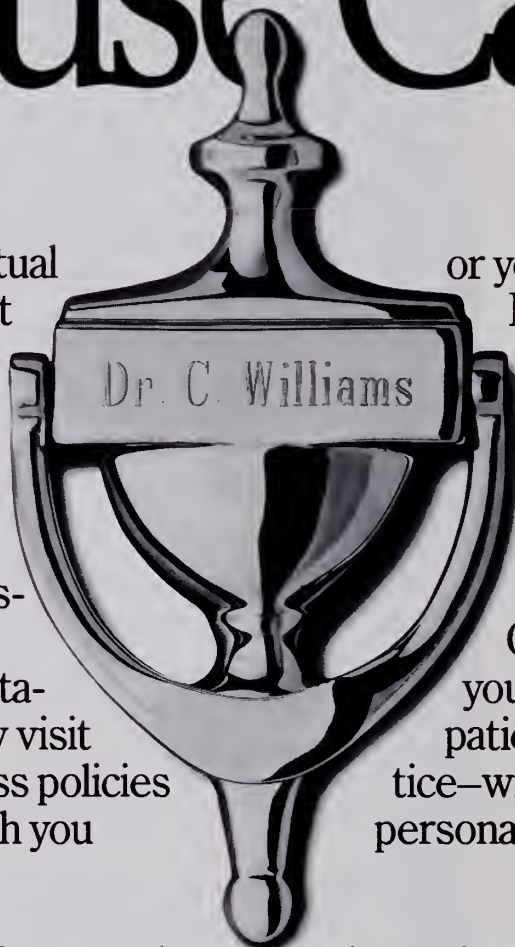
The Centers for Disease Control (CDC) AIDS reporting forms have been revised. If you have a case of AIDS or ARC to report and need a copy of the new form, please call (614) 466-5480 with your request. Completed forms should be returned to the ODH AIDS Unit to the attention of Lois Hall.
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QUOTES OF NOTE On Stress

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break. And use
humor. It's the lotion
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life." —Robert Eliot, MD**

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Transcutaneous Cardiac Pacemakers: Recent Advances

By Howard A. Werman, MD

Many clinical situations arise which require the immediate availability of cardiac pacing capabilities. Until recently, temporary transvenous cardiac pacemakers represented the only method available in these situations. Over the past few years, advances in transcutaneous cardiac pacing (external cardiac pacemakers, noninvasive temporary cardiac pacemakers) have provided the physician as well as other health professionals with a rapid, noninvasive method of establishing an effective cardiac rhythm. The purposes of the present article are to: (1) review the history of transcutaneous cardiac pacing, (2) describe features of the transcutaneous cardiac pacemaker, (3) discuss advantages and disadvantages associated with use of the device and (4) describe some clinical applications of the transcutaneous pacemaker.

History

Since the late 18th century, it has been known that electrical stimulation of the heart can produce effective myocardial contractions.¹ The clinical application of this principle to provide a paced cardiac rhythm

first appeared in the literature in the late 19th century.^{2,3} In 1952, Zoll⁴ reported the use of the transcutaneous pacemaker in two patients with Stokes-Adams attacks. In this initial report, the electrical stimulus for pacing was applied through needles placed in the subcutaneous tissues. In 1954, the same authors reported 14 patients with Stokes-Adams disease in whom transcutaneous pacing was employed.⁵ The device was modified to include three-centimeter circular electrodes which were applied to the chest wall. The electric stimulus was delivered over 2-3 milliseconds at a frequency of up to 180 beats per minute with a maximum amplitude of 150 volts. In this report, the authors noted several untoward effects of this pacing technique; these included painful muscular contractions and superficial burns of the skin. Further work was continued by Leatham⁶ who modified the transcutaneous cardiac pacemaker to include larger skin electrodes and a longer pulse duration.

With the introduction of transvenous pacing techniques and their successful use in the critical care setting, interest in transcutaneous pacemakers

diminished. In 1981, Hazard⁷ reported that transvenous pacemakers could not be reliably placed in patients with cardiac arrest. Brown⁸ also reported that transthoracic pacemaker placement, an alternative method of cardiac pacing during cardiac arrest, was also inaccurate in this setting using standard approaches. This information and concerns over the invasive nature of transvenous and transcutaneous pacing led to renewed interest in transcutaneous techniques. Reports began to appear in 1983 describing the use of the newer transcutaneous pacemakers⁹ that contained modifications designed to reduce problems associated with early models.

Description of the Device

With the resurgent interest in the device, several models of transcutaneous cardiac pacemakers have appeared on the market. To describe each one individually in this brief review would be impossible, so only the salient features are covered here. Most of the transcutaneous pacing devices used are capable of functioning in either the demand or asynchronous mode. The internal circuitry of the devices is designed to detect the

QRS complex. Most models are equipped to display the electrocardiographic tracing or can be coupled easily to an existing monitor/defibrillator which can display the EKG tracing. The stimulus can usually be varied from 0 to 180 beats per minute. Three major modifications in the present-day transcutaneous pacing devices have reduced many of the adverse effects noted with the early models.

The first is the increased size of the chest electrodes. Various devices use self-adhesive, high-impedance, pre-gelled electrodes which range from 6-16 cm in diameter. An additional modification is an increased pulse duration. The duration of the electrical stimulation of the newer transcutaneous pacemaker varies from 10 to 40 msec. Finally, modifications have been made in the amount of current applied. Most modern day machines can deliver a maximum of 140 to 200 mA. These higher current energies are needed to overcome the increased transthoracic resistance associated with the transcutaneous technique compared to other pacing methods.

Most transcutaneous pacemakers are simple to use. The self-adhesive electrodes are placed in an anterior-posterior orientation on the patient's thorax. The negative electrode is placed over the apex of the heart. A variety of positions have been suggested for the posterior electrode including positioning between the scapulae, beneath the left scapula or beneath the right scapula. A recent study¹⁰ suggests that the exact position of the posterior electrode has little bearing on the ability to pace the patient or the capture threshold (the minimum energy needed to establish electrical capture). Once the electrodes are applied, the pacing mode (demand or asynchronous) and desired rate are

selected. The current stimulus is initiated at a low level and increased incrementally until electrical capture is noted. The pacing threshold has been reported to be between 55 and 90 mA in normal subjects,^{10,11} but is higher in those conditions likely to require external pacing (hemodynamically unstable bradycardia, cardiac arrest).

Advantages/Disadvantages

Transcutaneous cardiac pacing is a rapid, safe and effective method of establishing a cardiac rhythm. Several studies have attested to the safety of the technique. Syverud¹² showed that prolonged transcutaneous pacing in dogs did not cause significant myocardial damage as evidenced by a lack of electrocardiographic changes, of elevations in myocardial enzymes or of derangements in clinical parameters. Kicklighter¹³ further showed that only minor changes could be seen grossly and microscopically in dogs paced

that cardiac output and mean arterial pressure were significantly improved over transvenous pacing. These results have been confirmed in clinical studies that have shown that capture rates with transcutaneous pacing is equal to¹⁷ or better than¹⁸ those achieved with transvenous pacemakers in the setting of cardiac arrest.

Application of the transcutaneous pacemaker can be performed rapidly and require little skill when compared to more invasive techniques (transvenous pacemakers, transthoracic pacemakers). The device may be safely used by properly-trained, non-physician personnel. Reports in the literature have appeared demonstrating the ability of prehospital personnel to use the transcutaneous pacemaker.¹⁹

On the other hand, there are some disadvantages with the technique. There are several clinical conditions that may elevate the transcutaneous pacing threshold to the point of making

Application of the transcutaneous pacemaker can be performed rapidly and requires little skill when compared to more invasive techniques.

transcutaneously for 30 minutes. These experimental studies have been confirmed by clinical studies documenting the safety of the procedure.^{11,14}

The effectiveness of this method has been well documented compared to transvenous cardiac pacing. In experimental studies, Vargese¹⁵ showed that the ventricular pressures produced by transcutaneous pacing was similar to that produced by transvenous techniques. Niemann¹⁶ further demonstrated the efficacy of this transcutaneous pacing and found

this pacing method ineffective. Patients with severe hypoxia, cardiomyopathies, heavy thoracic musculature and chronic obstructive pulmonary disease have been difficult to pace using this method.^{11,14} In addition, difficulty has been reported with adherence of the electrodes in diaphoretic individuals.

Although the modern transcutaneous pacemakers have been redesigned to reduce the intensity of muscular contractions, some conscious patients still report intolerance to these contractions.¹¹

The tolerance for the procedure may be increased by sedating the patient.²⁰ Finally, both electrical and mechanical capture have been difficult to identify in patients paced by transcutaneous techniques. Skeletal muscle contractions have made it difficult to determine the presence or absence of a pulse while the transcutaneous pacemaker is functioning.^{9,18} In addition, because the electrical stimulus produced by the transcutaneous pacemaker can produce significant artifact on the EKG tracing, electrical capture is often difficult to ascertain. Capture can be recognized if a QRS complex is associated with a pacing spike and is more than 0.14 msec, a T wave follows the pacing spike/QRS complex and any underlying rhythm is lost.¹⁸

Clinical Applications

Bradycardia: Since the initial report by Zoll⁴ documenting the use of transcutaneous pacing in Stokes-Adams disease, reports have appeared demonstrating the efficacy of the device in patients with hemodynamically unstable bradycardias. Transcutaneous pacing has been used successfully in patients with bradycardia secondary to spinal trauma,²¹ surgical procedures²² and following cardioversion from atrial fibrillation.²³ In these patients, transcutaneous cardiac pacing can be initiated while more definite methods (fluoroscopically-placed transvenous pacemakers) are being established.

Asystole/Pulseless

idioventricular rhythm: Cardiac arrest from asystole and pulseless idioventricular rhythm carries a dismal prognosis. Less than 10% of these patients survive to be admitted to the hospital²⁴ and far less than 1% are long-term survivors.²⁴⁻²⁶ While cardiac pacing has been recommended as a final

measure when pharmacologic therapy has failed, studies have suggested that early application of cardiac pacing may improve survival in asystolic cardiac arrest.^{27,28} Because of the ease and rapidity with which transcutaneous pacing can be established, this technique has been evaluated in this setting.

Some early reports in which transcutaneous cardiac pacemakers were used in patients with asystole or pulseless idioventricular rhythm showed no improvement in patient survival.^{9,18,19,29-31} However, in these

Other applications: Because the transcutaneous pacemaker has the ability to deliver up to 180 stimuli per minute, the potential for overdrive pacing of cardiac tachydysrhythmia exists. Only limited clinical experience with the use of the transcutaneous pacemaker in these circumstances has been reported. Zoll¹⁴ attempted overdrive pacing in eight patients with a variety of atrial and ventricular tachydysrhythmia and found the transcutaneous pacemaker clinically useful in only one case.

Transcutaneous pacing has been used successfully in patients with bradycardia secondary to spinal trauma, surgical procedures and after cardioversion from atrial fibrillation.

studies, long periods of time had often elapsed until transcutaneous pacing was employed. In those studies in which transcutaneous pacing was initiated within five minutes of the cardiac arrest, the data has been very encouraging. Zoll¹⁴ reported a mechanical response in 15 of 16 patients with cardiac arrest of less than five minutes duration and short-term survival in 12. Syverud¹⁷ reported full neurologic recovery in two of five patients in which transcutaneous pacing was initiated within five minutes of asystolic cardiac arrest.

These reports suggest that early application of pacing techniques in victims of cardiac arrest with an underlying rhythm of asystole or pulseless idioventricular rhythm may improve survival. Because of the noninvasive nature of the technique, ease of application and safety, transcutaneous cardiac pacemakers may have a significant role in this area.

Beaudry,³² on the other hand, described a patient with ventricular tachycardia who was successfully converted using the device. Clearly, more extensive clinical trials are needed to determine the efficacy of transcutaneous pacing in this setting.

It has also been suggested that the transcutaneous pacemaker may be useful in readiness for high-risk patients likely to develop any of the above dysrhythmias. Such applications might include patients with acute myocardial infarction, patients with suspected dysrhythmias or patients undergoing operative procedures for permanent pacemaker placement. Again, clinical experience has been limited in this area.

Summary

There has been renewed interest in the transcutaneous cardiac pacemaker in the recent medical

continued on page 137

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literature. This device provides a safe, effective and noninvasive method of establishing myocardial activity in a clinical setting where pacing is indicated.

Transcutaneous pacing has been shown to be clinically useful in patients with hemodynamically significant bradycardias. It may also be helpful in patients with early asystolic cardiac arrest, with atrial or ventricular tachydysrhythmias and as a prophylactic measure in certain high-risk patients. Because of its noninvasive nature and lack of complications, greater clinical application of this device is anticipated.

Howard A. Werman, MD, is Assistant Professor, Ohio State University College of Medicine, Columbus.

REFERENCES

- Galvani L: De Viribus electricitatis in motu commentarius 1791.
- Duchenne de Boulogne: De l'électrisation localisée et son application à la pathologie et à la thérapeutique. Baillière. Paris, 1872.
- Von Ziemssen H: Studien ueber die bewegungsvorgaenge am menschlichen herzen, sowie ueber die mechanische und elektrische erregbarkeit des herzens und des nervus phrenicus, angelstellt an dem freiliegenden herzen der catherina serafin. Arch Klin Med 30:270, 1882.
- Zoll PM: Resuscitation of the heart in ventricular standstill by electrical stimulation. NEJM 247:768-771, 1952.
- Zoll PM, Linenthal AJ, Norman LR: Treatment of Stokes-Adams disease by external electric stimulation of the heart. Circulation 9:482-493, 1954.
- Leatham A, Cook P, Davies JG: External electric stimulator for treatment of ventricular standstill. Lancet 2:1185-1189, 1956.
- Hazard PB, Benton C, Milnor JP: Transvenous pacing in cardiopulmonary resuscitation. Crit Care Med 9:666-668, 1981.
- Brown CG, Gurley HT, Hutchins GM, et al.: Injuries associated with percutaneous placement of transthoracic pacemakers. Ann Emerg Med 14:223-228, 1985.
- Falk RH, Jacobs L, Sinclair A, et al.: External noninvasive cardiac pacing in out-of-hospital cardiac arrest. Crit Care Med 11:779-782, 1983.
- Falk RH, Ngai ST: External cardiac pacing: influence of electrode placement on pacing threshold. Crit Care Med 14:931-932, 1986.
- Falk RH, Zoll PM, Zoll RH: Safety and efficacy of noninvasive cardiac pacing: a preliminary report. NEJM 309:1166-1168, 1983.
- Syverud SA, Dalsey WC, Hedges JR, et al.: Transcutaneous cardiac pacing: determination of myocardial injury in a canine model. Ann Emerg Med 12:745-748, 1983.
- Kicklighter EJ, Syverud SA, Hedges JR, et al.: Pathological aspects of transcutaneous cardiac pacing. Am J Emerg Med 3:108-113, 1985.
- Zoll PM, Zoll RH, Falk RH, et al.: External noninvasive temporary cardiac pacing: clinical trials. Circulation 71:937-944, 1985.
- Varghese PJ, Bren G, Ross A: Electrophysiology of external pacing: a comparative study with endocardial pacing. Circulation 66 (Suppl II):349, 1982 (abstract).
- Niemann JT, Rosborough JP, Garner D, et al.: External non-invasive cardiac pacing: a comparative hemodynamic study of two techniques with conventional endocardial pacing. PACE 7:230-236, 1984.
- Syverud SA, Dalsey WC, Hedges JR: Transcutaneous and transvenous cardiac pacing for early bradycardiac arrest. Ann Emerg Med 14:500-501, 1985 (abstract).
- Dalsey WC, Syverud SA, Hedges JR: Emergency department use of transcutaneous pacing for cardiac arrests. Crit Care Med 13:399-401, 1985.
- Paris PM, Stewart RD, Kaplan RM, et al.: Transcutaneous pacing for bradycardiac arrests in prehospital care. Ann Emerg Med 14:320-323, 1985.
- McNeil EL: Successful resuscitation using external cardiac pacing. Ann Emerg Med 14:1230-1232, 1985.
- Kay MM, Kranz JM: External transcutaneous pacemaker for profound bradycardia associated with spinal cord trauma. Surg Neurol 22:344-346, 1984.
- Berliner D, Okum M, Peters RW, et al.: Transcutaneous temporary pacing in the operating room. JAMA 254:84-86, 1985.
- Sharkey SW, Chaffee V, Kapsner S: Prophylactic external pacing during cardioversion of atrial tachyarrhythmias. Am J Cardiol 55:1632-1634, 1985.
- Myerburg RJ, Kessle KM, Zamam L, et al.: Survivors of prehospital cardiac arrest. JAMA 247:1485-1490, 1982.
- Iseri LT, Humphrey SB, Siner EJ: Pre-hospital bradycardiac arrest. Ann Intern Med 88: 741-745, 1978.
- Eisenberg M, Hallstrom A, Bergner L: The ACLS Score: predicting survival from out-of-hospital cardiac arrest. JAMA 246:50-52, 1981.
- Edhag O, Nyquist O, Orinius E, et al.: Cardiac pacing through transthoracic electrode in acute myocardial infarction. Acta Med Scand 192:145-147, 1972.
- Baksi KB, Hossain A, Chopra DS, et al.: Transthoracic pacing in ventricular asystole. J Indian Med Assoc 60:134-137, 1973.
- Clinton JE, Zoll PM, Zoll R, et al.: Emergency noninvasive external cardiac pacing. J Emerg Med 2:155-162, 1985.
- Olson CM, Jastremski MS, Smith RW, et al.: External cardiac pacing for out-of-hospital bradycardiac arrest. Am J Emerg Med 3:129-131, 1985.
- White JW, Nowak RM, Martin GB, et al.: Immediate emergency department external cardiac pacing for prehospital bradycardiac arrest. Ann Emerg Med 14:298-302, 1985.
- Beaudry PR, Rosengarten MD, Nadeau L: Termination of ventricular tachycardia with transcutaneous cardiac pacing. Can Med Assoc J 134:145-146, 1986.



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BOOK REVIEW

Health-Care Costs

*Edited by Carl J. Schramm;
Norton Publishing
Company; 301 pages; \$18.95*

This book contains the background papers presented at the 72nd American Assembly Meeting addressing the future of the United States' health-care delivery system in November 1986. The Assembly is a National Educational Institution that provides information, discussion and independent conclusion on matters of public interest. It was established by Dwight D. Eisenhower at Columbia University in 1950 and meets twice a year.

The book's eight chapters, each an individual 10,000-word essay, are written by well-recognized individuals in health-care related fields. The subtitle, "Can the United States Afford Adequate Health Care?" is but a portion of the more central theme, the influence of the past as a determinate of the future of that delivery system. The topic is addressed from several different vantage points: medicine, business, insurance, government, consumer, patient, planner. The volume makes the bold approach to discussing the past, present and future of that system. We must know the pressures that will change that system to accept and meet the challenge to preserve the best aspects of the health-care system.

Formal attention to health-care cost and policy began in the 1930's with the advent of private insurance and the post-war Hill-Burton Hospital building program followed. Medicare and Medicaid in the 1960's guaranteed the poor and elderly access to care. The federal government became an actor in the system. Then, cost was not an issue; the economy was

booming. But times have changed. The cost of health care has escalated to over \$450 billion dollars annually, 10% of the Gross National Product. Now, the cost coupled with medicine's rapid technological advances, the changing roles of physicians, the shifting population, the aging phenomenon, social evolution, health-care policy, and new delivery systems are factors causing concern for the continued adequacy of health care in this country.

The book's editor, Dr. Schramm, is the Director of the Center for Hospital Finance and Management, The Johns Hopkins Medical Institutions. His impressive authors review their subjects in depth, weave the big picture of the system in its present state and make a forecast for the future of health care. The book begins with Steven Renn discussing the health-care delivery system structure and the financing for that system using sound basic facts. Robert Blendon and Drew Altman address the public sector's position on costs and access to health care. How medicine has fared and will fare as a profession in the changing environment is provided by Donald Cohodes. The editors use Susan Feigenbaum to discuss responsibility in the health-care system. She gives an insightful view on where the risks are and who should share them. Robert Ebert, MD, who served as president of the Harvard Medical Center and dean of the Harvard Medical School, writes a concise review on the changing role of the physician from colonial days to the era of the computer. The dynamic issues of our aging population and demographic shifts and the whole spectrum of problems relating to long-term care are thoroughly presented. The concluding paper addresses the impact by technology and the policy structure of many facets

relating to that field.

The book concludes with the report of the Assembly, a series of recommendations toward the future of the health-care delivery system. The questions of affordability of health care and how the system is maintained to provide adequate health care are not answered by the Assembly. The Assembly's purpose, to put the problems of the health-care system in greater perspective, is achieved.

The book is well written and very readable. Each chapter has a bibliography and each subject is well covered by the author.

"Health-Care Costs" summarizes the past and present, and makes recommendations to influence the future of the health-care system in the United States. New information on this complicated subject is not presented. It is designed to stimulate informal discussion at the American Assembly and is an excellent, concise and accurate review of the whole picture of the problems surrounding the health-care delivery system and the costs of that system in this country.

Students and young physicians will find the book instructive and offering a prospective, important to their professional lives. To all physicians, it is recommended reading. It will serve as an excellent review to those familiar with the problems and it is an excellent base to those physicians who need to catch up and be effective in making and influencing health-care system decisions. — **Thomas E. Gretter, MD, Quality Assurance Officer, Cleveland Clinic Foundation, Cleveland.**

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OBITUARIES

DANIEL G. COOK, MD, Tryon, NC; Ohio State University College of Medicine, 1948; age 66; died October 14, 1987; member OSMA and AMA.

JOHN R. DICKASON, MD, Vermilion; University of Louisville School of Medicine, Louisville, KY, 1933; age 81; died October 14, 1987; member OSMA and AMA.

JAN "IAN" FALENSKI, MD, Columbus; Akademia Medyczna Wydział Lekarski, Warszawa, Poland, 1923; age 98; died November 6, 1987; member OSMA and AMA.

KARL FINNEN, MD, Cincinnati; Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1960; age 60; died October 15, 1987; member OSMA and AMA.

KURT FLEISCH, MD, Columbus; Facolta Di Medicina e Chirurgia dell

'Universita di Roma, Roma, Italy, 1936; age 75; died October 15, 1987; member OSMA and AMA.

ALLISON ERRINGTON, MD, Winter Garden, FL; Ohio State University College of Medicine, 1926; age 85; died November 4, 1987; member OSMA and AMA.

WARREN W. GIDDENS, MD, Cincinnati; Loyola University Stritch School of Medicine, Maywood, IL, 1959; age 54; died October 3, 1987; member OSMA and AMA.

WILLIAM H.R. HOWARD, MD, Sanibel Island, FL; Case Western Reserve University School of Medicine, 1942; age 71; died November 12, 1987; member OSMA and AMA.

LYMAN F. HUFFMAN, MD, Cleveland; Johns Hopkins University School of Medicine, Baltimore, MD, 1914; age

97; died September 10, 1987; member OSMA and AMA.

HENRI LeCLAIRE, MD, Cincinnati, Loyola University Stritch School of Medicine, Maywood, IL, 1941; age 79; died October 17, 1987; member OSMA and AMA.

FRANCIS W. McCOY, MD, Sunbury; Ohio State University College of Medicine, 1942; age 73; died October 15, 1987; member OSMA and AMA.

FLOYD POTTER, MD, Sun City Center, FL; University Cincinnati College of Medicine, 1941; age 73; died November 8, 1987; member OSMA and AMA.

FREDERICK I. ROSE, MD, Columbus; Ohio State University College of Medicine, 1953; age 72; died October 22, 1987; member OSMA and AMA.

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A Reawakening

Interest . . .

continued

ones, in the years ahead."

Dr. Cobau agrees.

"We're seeing that now," he says. "The likelihood of a person dying from cancer is going up at about one percent per year."

On the other hand, more and more cases of cancer are also being cured.

"The cure rate is about 50 percent now," says Dr. Cobau, "and in the next ten years, given the type of advances medicine usually makes in that length of time, it's possible that we can anticipate the cure rate being closer to 60 percent."

Which sounds like a very promising note for the future, indeed. Of course, just what effect OSMA's Committee on Cancer will have in speeding that prognosis along has yet to be determined.

Dr. Newton's frustrations are surely typical of most medical professionals who long for the staff, the money, as well as the time to tackle cancer head-on, and to come up with a quick solution before many more lives are lost.

But Dr. Cobau has the kind of tortoise patience that may yet prove to be effective.

"I've been in cancer, and medicine, long enough to know that nothing is ever accomplished soon. Any headway that is made, is always made very slowly," he says.

Yet even that bit of "resigned philosophy" is not entirely discouraging.

After all, as Aesop always told us, it was the tortoise who eventually won the race. OSMA

Karen S. Edwards is the Executive Editor of OHIO Medicine.

CONTINUING MEDICAL EDUCATION

Evaluation and Management of Balance Disorders

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Contact: June Hosick, Director Educational Services
The Christ Hospital
2139 Auburn Avenue
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Sponsor: Communicative Disorders Foundation

Contact: Robbie Cornelison,
Program Coordinator
Department of Otolaryngology and Max. Surgery
University of Cincinnati Medical Center,
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continued on page 147



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References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiaro SR, Wojciechowski NJ, et al. Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiaro SR. Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE)

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100	NDC 0083-0165-30
Bottles of 1000	NDC 0083-0165-40
Consumer Pack—One Unit	
12 Tablets—100 tablets each	NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)	
Box of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

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Treating Your Practice — III

Keeping In Touch With Your Patients

By the OSMA Department of Communications and Physician Marketing

Editor's note: *This is the third article in a series on physician marketing, extracted from the OSMA Physician's Marketing Handbook.*

Even after a successful physician-patient encounter, there are no guarantees that a patient will continue to patronize you. He or she may decide to disregard your advice, to skip or cancel the next appointment or to transfer his or health care to another physician.

Your follow-up correspondence with patients after they leave your office can be just as important in keeping them as patients as your communications with them at the time of their visits. You can keep in touch with your patients by telephone, by mail and by questionnaires designed to allow them an opportunity to offer you some suggestions.

In addition, there is the touchy matter of collecting for your services. The techniques you use to call attention to unpaid bills not only make the difference between getting paid or not getting paid;

they also determine whether or not a patient and his or her family and/or friends will continue to look upon you as a caring and understanding health-care provider in the future.

Telephone Calls

- Use your telephone for all it's worth: to remind patients of upcoming appointments, to say the doctor is on time or is running late, to relate lab test results (both good and bad), to see how a patient is responding to treatment and to consult with family members about a patient's condition. Never underestimate the effectiveness of a personal call. Patients know how busy you are and when you personally call a patient, it makes a big impression.

- Set aside a special time of day to return patients' phone calls — and have your staff relay that time to your patients, so they don't

wait all day for your call.

- Reserve a time for patients to call into your office with their health-care concerns.

- Avoid putting patients on "hold" for long periods of time in order to answer other calls. If this occurs repeatedly, you probably need a second receptionist.

- Ask the telephone company to monitor your line to determine how many callers get busy signals when they call into your office and the time of day your office gets the most phone calls. Better scheduling of staff or a second line may be indicated.

- Consider installing a toll-free number or a local line in a nearby community so that patients don't have to pay long distance to make an appointment or call you with their problems.

- If you use an answering machine when you are not in the office, make sure you leave a clear

List patient complaints on a ledger, and keep tally of them. If a number fall into one area, take visible steps to correct them, and let your patients know you are doing so.

message as to how you can be reached in an emergency — and who is filling in for you in your absence. Also check regularly to make sure it is in good working condition.

- If you employ an answering service, check periodically to make sure that it is providing a quality service.

Mailings

- Make a regular habit of sending post cards to remind patients of appointments, especially those scheduled more than a month in advance.

- Send periodic notices or postcards to patients reminding them of the need for immunizations, regular physicians, school check-ups, etc.

- Send a personalized patient newsletter of your own creation (or order OSMA's *Health Hints*) to remind patients of you and your practice.

- Send holiday cards, birth cards, etc. to regular patients as a token of friendship.

- Mail sympathy notes to the relative of deceased patients — if appropriate, flowers or a personal visit may be in order.

- Develop a logo and use it on all printed materials: business cards, envelopes, billings, stationery, script pads, etc. Make sure it portrays the image you want to give: warm and friendly, high-tech, etc.

Soliciting Patient Responses

- Distribute patient questionnaires — in the office, in the reception area or by mail to all of your patients. Questions

should cover the way your patients are treated by office staff, physician, etc., as well as basic demographics: age, sex, marital status, etc. Not only do they provide patient input, they also remind patients that you exist and that you care.

- Make phone calls to those patients who have repeatedly cancelled appointments or asked to have their records transferred elsewhere, asking why they have switched.

- Place a suggestion box in your reception area and encourage patients to submit tips on how you can help them better.

- List patient complaints — both written and verbal — on a ledger and keep tally of them. If a number fall into one area — such as “waiting time is too long” — take visible steps to correct them and let your patients know that you are doing so.

The Touchy Matter of Collections

Many physicians don't like to think or talk about payment for their services — they prefer that their office staff take care of the touchy matter of unpaid bills. But too many delinquent accounts can have a serious impact on your ability to continue practicing medicine. What's more, physicians need to be comfortable talking to their patients about fees, since more and more attention is being drawn to the high cost of health care and many patients are asking questions about charges for care.

The following are some tips for avoiding problems with collections and for handling them once they occur.

- Make a written fee schedule available to patients upon request, so that they will know in advance what certain procedures will cost them — and what is likely to be covered by insurance.

- Make your payment policies as clear as possible — post them in writing in your reception area, explain them to new patients at the time of their first visit and include them in all written communications with your patients.

- Help patients to understand the type of insurance coverage they have — how much of their bill should be covered by insurance and how much in co-payments and deductibles they will have to pay themselves.

- When possible, ask for payment at time of visit, or insist that insured patients submit completed insurance forms before they leave the office.

- Encourage patients to discuss any financial problems with you in advance to avoid misunderstandings and to devise some system for payment agreeable to all.

- Take time to help patients fill out their insurance forms properly or complete the forms for them, getting their name, address, social security number, policy number and signature.

- When appropriate, ask patients to sign direct authorization of insurance payments to you, in order to avoid delays and misunderstandings on what the patient owes and what the insurance company will pay.

- When first approaching a

delinquent account, ask if the patient is experiencing financial difficulties — and if there is any way you can be of assistance. Make it clear that you value and want to keep the patient's business.

- Handwritten personal notes often are more effective than computerized billing statements in convincing a patient to pay a bill. They also help the patient to feel better about the situation.

Collection letters should be signed by the office manager. But as a last resort, a personal note from the physician may help make a patient feel obligated to pay.

- Before turning an account over to a collection agency, which will charge you 40% to 50% of the proceeds, consider offering the patient a 10% or 20% discount for an immediate cash payment.

- Don't delay in contacting a patient about an unpaid account. Remember, the longer the bill goes unpaid, the less likely the patient is to feel obligated to pay it. **OSMA**

Next month, the final installment will feature "Getting Professional Help."

Second Opinion . . . *continued*

power to plunder the Constitution and a (any) segment of the population.

While your administration is pursuing **privitization** in practically all fields — in the field of medicine your administration is opting for public ownership, socialization, and public control.

Incredible!

I would appreciate hearing from you at the earliest possible time.

Warmest best wishes — always.

Gratefully and Faithfully,

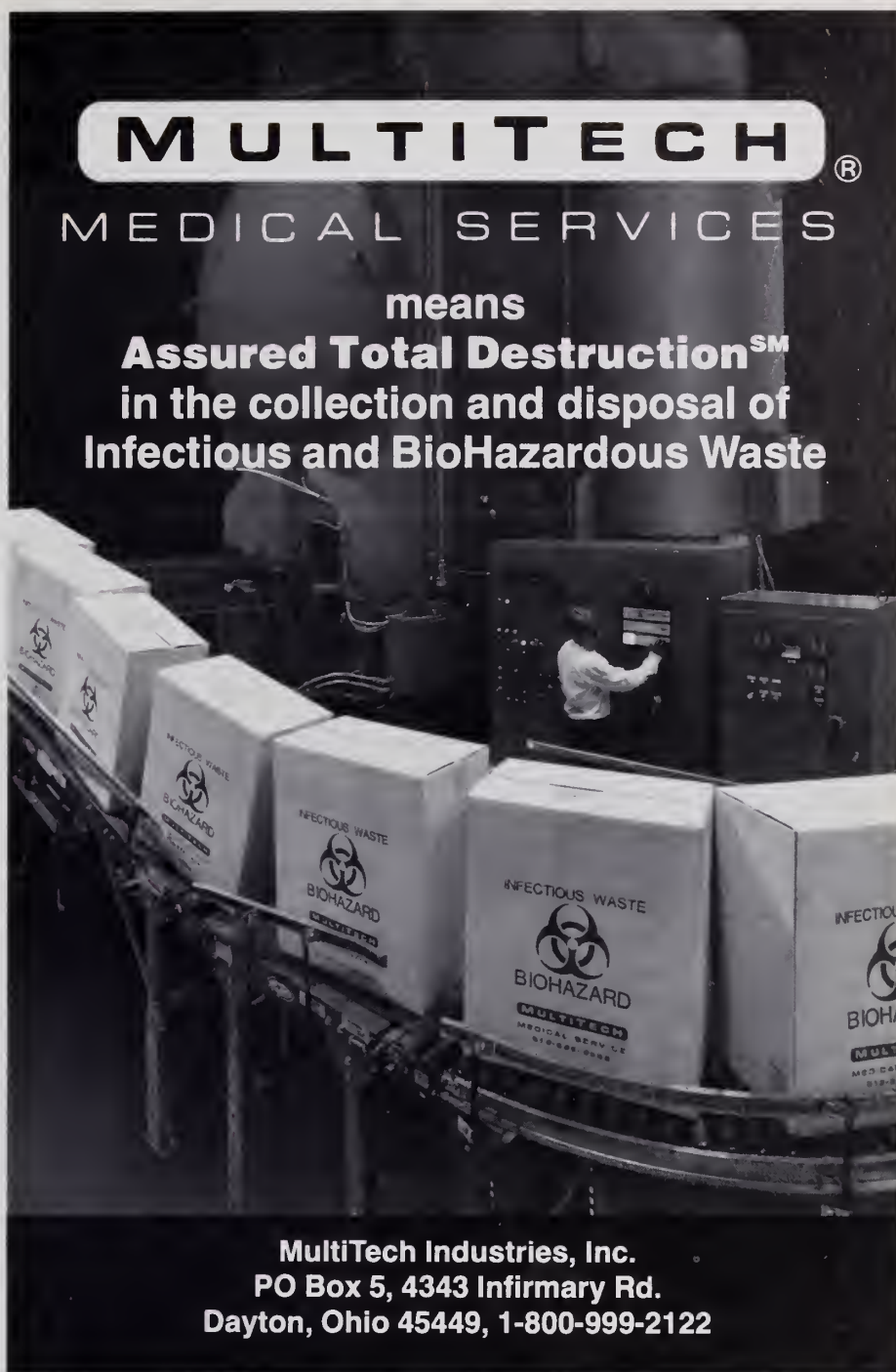
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513-872-4233

President's Page . . . *continued*

result from every medical encounter, this may be the only feasible solution.

It is clear to me the current situation cries out for new and innovative ideas to resolve a health-care problem of great magnitude — for physicians and patients alike. While no one would seek to limit any individual's right to just compensation for legitimate injury, I think it has become

continued on page 151

OSMA Auxiliary

Day at the Legislature

Hyatt on Capitol Square
Columbus, Ohio

Wednesday, March 9, 1988

- | | |
|--|--|
| 8:30 A.M. Registration & *Continental Breakfast | 11:00 A.M. Senator David Hobson, Chairman,
Committee on Health, Human
Services & Aging |
| 9:15 A.M. Briefing on Current Federal Legislation
John Kasper, Field Rep., AMA | |
| 10:00 A.M. Vernal G. Riffe, Jr., Speaker, House
of Representatives | 12:00 Noon **Luncheon with Legislators |
| 10:30 A.M. Briefing on Current State Legislation
Richard A. Ayish, Associate
Executive Director, OSMA
Legislation Dept. | 1:15 P.M. Attend Sessions/Hearings Workshop
— Activate in '88
Involvement in the 1988 election
through active participation |

***Continental Breakfast:**

Chilled juices, danish pastries, muffins,
croissants, specialty breads, butter and preserves,
coffee or tea.

**** Luncheon:**

Cream of domestic mushroom soup
Hot ham & turkey sandwich on rye bread with
cheddar cheese melt
Cold Kaluha souffle — Beverage

Registration Fee: \$25.00 per person (includes breakfast, luncheon, workshop, materials)

Make check payable to: OSMA Auxiliary — no reservations without a check

Reservation Deadline: February 16, 1988

Send check and form to: Sue Massie,
1001 Mastin Avenue, Ironton, Ohio 45638

For Room Reservations: Contact the Hyatt on Capitol Square (614) 228-1234
Identify yourself as being with the OSMA Auxiliary
Rates: \$76 for a single, \$86 for a double

DEADLINE FOR ROOM RESERVATIONS: February 6, 1988

_____ Yes, I will attend the Day at the Legislature, March 9, 1988

_____ I understand an invitation has been extended to the legislators by Joyce Johnson, OSMA-A
President, but I will personally contact my State Senator/State Representative to
attend _____

Senator/Representative

NAME _____

ADDRESS _____

CITY _____ ZIP _____ COUNTY _____

I will attend Continental Breakfast _____ Luncheon _____ Session _____ Workshop _____

**IF YOU ARE MAKING RESERVATIONS FOR OTHER PEOPLE PLEASE SEND THEIR NAMES &
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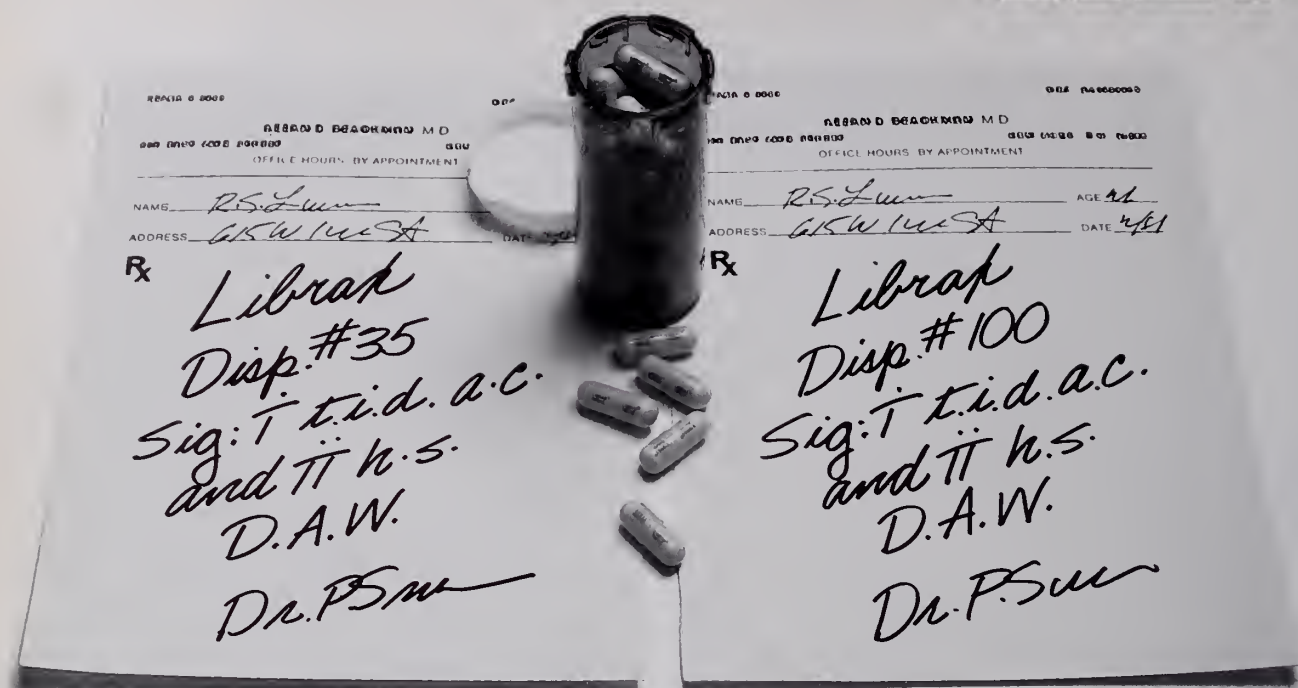
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*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and the irritable bowel syndrome.

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Specify
Adjunctive

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Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
“Possibly” effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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President's Page . . . continued

increasingly clear that the current system is out of control. In seeking a solution, we must work to assure that it is fair to everyone.

I encourage each Ohio physician to pass along their thoughts and suggestions on professional liability to me, as President of the OSMA, and to their OSMA Councilor. I also encourage each member to speak "from the heart" and communicate their concerns on this issue to their patients, to legislators and to community decision makers.

There is no doubt that the current situation presents medicine with a great problem. But I also believe it affords the medical professional an unusual opportunity — an opportunity to investigate, develop and promote much needed solutions to this problem. Once again, organized medicine can and must be **In Charge** for the right change. **OSMA**

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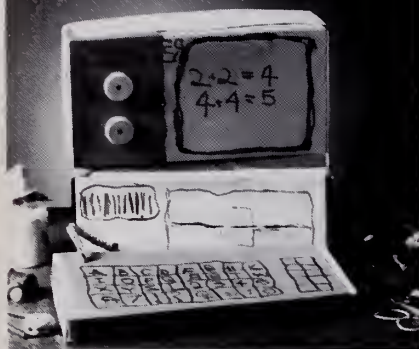
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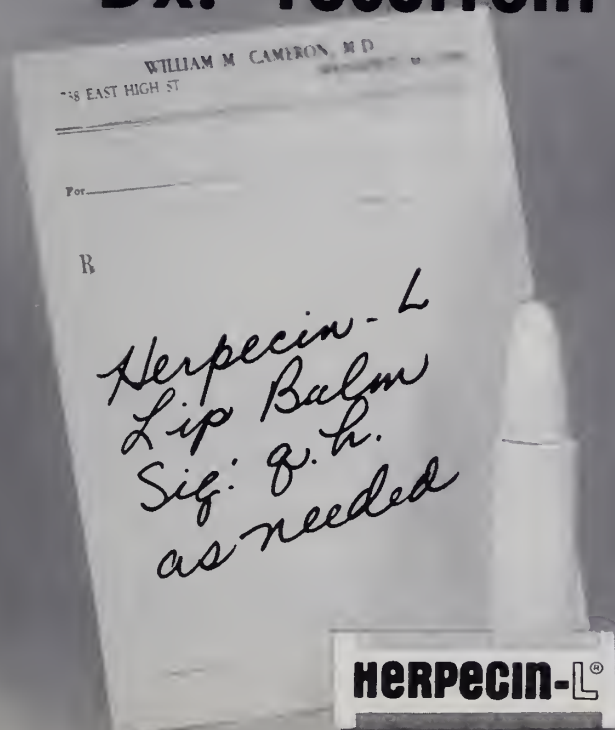
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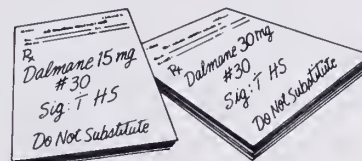
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References: 1. Zimmerman AM. *Curr Ther Res* 13:18-22, Jan 1971. 2. Amrein R, et al. *Drugs Exp Clin Res* 9(1):85-99, 1983. 3. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21:355-361, Mar 1977.



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Precaution: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

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VOL. 84, NO. 3

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References: 1. Feighner JP, et al. *Psychopharmacology* 61:217-225, Mar 22, 1979. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring

reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias at the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

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FROM THE EDITOR

Ethical Dilemmas

Every so often, it's important for medicine to step back and take a good look at how far it has come over the past few decades. Technological advancements have wrought near-miracles in many areas not used to miracles, like heart disease and cancer — yet perhaps nowhere is this statement more true than in the area of infertility.

Recent advances in in vitro fertilization, the new GIFT procedure, and the introduction of an entirely new element — surrogate mothering — have enabled previously infertile couples to bear healthy offspring. Other advances, also in this field, now allow expectant moms and dads to preselect the sex of their child (or at least improve the typical 50-50 odds).

But what are all of these advancements costing us — not in terms of a dollar-and-cents figure (many childless couples yearning for a baby will tell you money is no object), but in terms of our morality, our ethics, that standard of right and wrong that keeps our culture "civilized"?

That's the question *OHIO Medicine* has posed this month to four professionals, each of whom has a different perspective of the problem. The Honorable Lawrence Grey, Judge of the Fourth Appellate District Court in Athens, and a frequent contributor of this publication, presents us with a legal viewpoint; Peter Horn, an ethicist with Riverside Methodist Hospital in Columbus, allows us to see the question from a purely ethical view; and next month, two physicians — John Sanders, MD, an OB/GYN at the Cleveland Clinic, and Stanley Troup, MD, a professor of

Medicine, Health Care and Human Values at the University of Cincinnati's College of Medicine present their own unique perspectives, as they examine the human problems created by such rapid technological advancements. We think you'll find all four views both insightful — and thought-provoking.

In keeping with our ethical theme, Editorial Assistant Michelle Carlson provides a close-up look at Oscar Clarke, MD, the Gallipolis physician who was recently appointed to one of the most prestigious positions at the American Medical Association — its Council on Ethical and Judicial Affairs. Many of you already know Dr. Clarke, who has served in numerous positions at the OSMA — including a recent stint as Chairman of the Ohio Delegation (a position since capably assumed by Cleveland physician Dr. Ted Castele), but for those of you who don't know him — and even for those who do — here is a rare glimpse at the type of physician who is serving today as medicine's "collective conscience." We think you'll agree with us that the AMA (and medicine in general) couldn't have selected a better or more conscientious person to lead medicine into the future than Dr. Oscar Clarke. We congratulate him on his appointment.

Next month is our traditional program issue for the OSMA Annual Meeting. If you haven't already done so, mark May 20-22 on your calendar, and make plans now to be in Cincinnati. We'll see you there!

Karen S. Edwards

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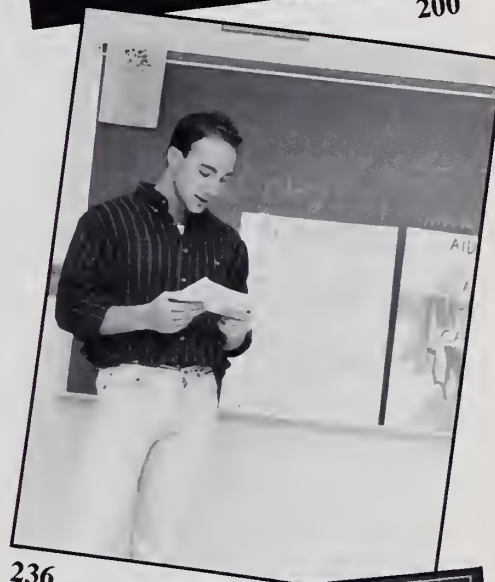
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OUR COVER

This month's cover was designed and illustrated by freelance artist-photographer Larry Hamill.



200

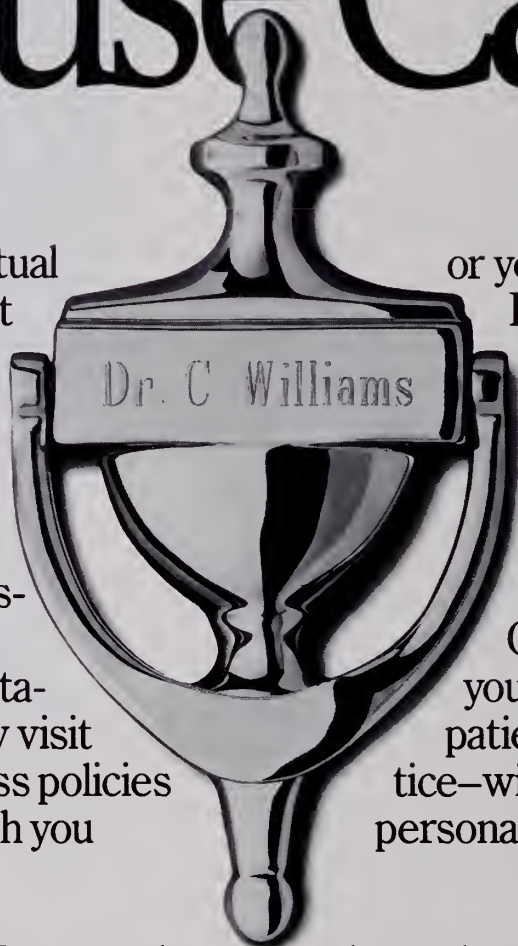


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“Beware the Ides of March”

Act 1, Scene II, Julius Caesar.

By D. Ross Irons, MD

You might ask what a soothsayer's call from the multitudes surrounding Caesar has to do with medicine today. The answer is simple. *Julius Caesar* is, at least in part, a political play. The main issue of the play is one of liberty and human rights. In essence the play's theme is a single one: liberty versus tyranny.

Which brings us to today. If ever Ohio physicians and Ohio patients have been entangled in a battle of liberty versus tyranny it is now. As the physicians and patients of Ohio play out our destiny in today's medical health-care forum, we, like Caesar, must be ever cognizant of the tyrants. Today these tyrants are more aptly described as the third-party payers, the government statutory agencies and, yes, even those “managed” health-care plans espoused by some of our own.

It seems that in our rush to be competitive we have not heeded the soothsayers in our ranks and now find ourselves in need of stringent review regarding what we are truly about.

A recent survey done in the state of Minnesota in regards to

competitive medicine has turned up some interesting points. Sixty-two percent of the physicians surveyed believed that prepaid plans have reduced their ability to act as an advocate for their patients. Fifty-seven percent reported that a third-party payer has limited treatment options they would have otherwise recommended. Forty-five percent

“... in our rush to be competitive, we have not heeded the soothsayers in our ranks . . .”

believe trust among physicians has declined. Seventy-six percent enjoyed medical practice less than they did five years previously and 85 percent of the physicians surveyed favored changing the law to make collective bargaining possible for physicians.

We must ask the questions, “Has the art of medicine been compromised by the new data processing capabilities and massive

information banks maintained by third-party payers and government agencies, and is this situation producing the impetus to quantify the outcome of medical treatment?” Quantifying the quality of medical care is a difficult, if not impossible, task. Some have said that only by giving up “the art” of medicine can quality really be quantified. Personally, I believe if this happens quality would likewise have to be relinquished along with the “art.”

If we are to avoid the runaway changes in the health-care arena, perhaps it is time to pause and heed the soothsayer's warning. The Ohio State Medical Association recently commissioned a study of physicians' attitudes and concerns regarding “managed” care and third-party payment programs. The OSMA believes that it is very important to understand the relationship of its members to these programs in order to address the issues, concerns and problems they present. The study, conducted as focus group interviews, identified eight problem areas:

continued on page 216

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LETTERS TO THE EDITOR

AIDS Testing

To the Editor:

I have some comments regarding the clinical update "AIDS Testing" which appeared in the December issue of *OHIO Medicine*, pages 837-839. I have had the opportunity to view the insurance industry from the inside during the last several years and I attest that it is a complicated industry, one which is not well understood and is frequently misunderstood. Perhaps I can add some clarity to one small piece of the misunderstanding.

Concerning HIV testing, the article states: "However, by submitting to such a test, the patient *risks losing* certain benefits (i.e. life and health insurance) if test results are positive . . ." (italics added for emphasis).

The truth of the matter is that if a person has life and health insurance currently in force, *that contract is valid* regardless of whether they subsequently test positive for HIV or myocardial ischemia or diabetes.

In another part of the article in bold face print we find: "the down side of testing positively is that the patient may be socially ostracized or *risk losing* job, home and insurance" (italics added for emphasis).

It is true that a positive HIV test may well have a social and economic impact on an individual to say nothing of the medical and psychological impact. It is *not correct*, however, to assert because a person tests positive for HIV they will *lose* insurance. An

insurance policy in force is a valid contract and unless it was obtained fraudulently, the insurer is duty bound to honor all commitments.

Most health insurance in the United States is purchased on a group basis without medical underwriting. That is to say, most people covered by health insurance obtained such coverage without testing or medical examination. The risk of disease and medical disability are spread among the members of the group and the price of that group insurance includes that common risk.

Individual health insurance is another issue altogether. If one buys individual insurance, underwriting may well occur and

continued on page 165

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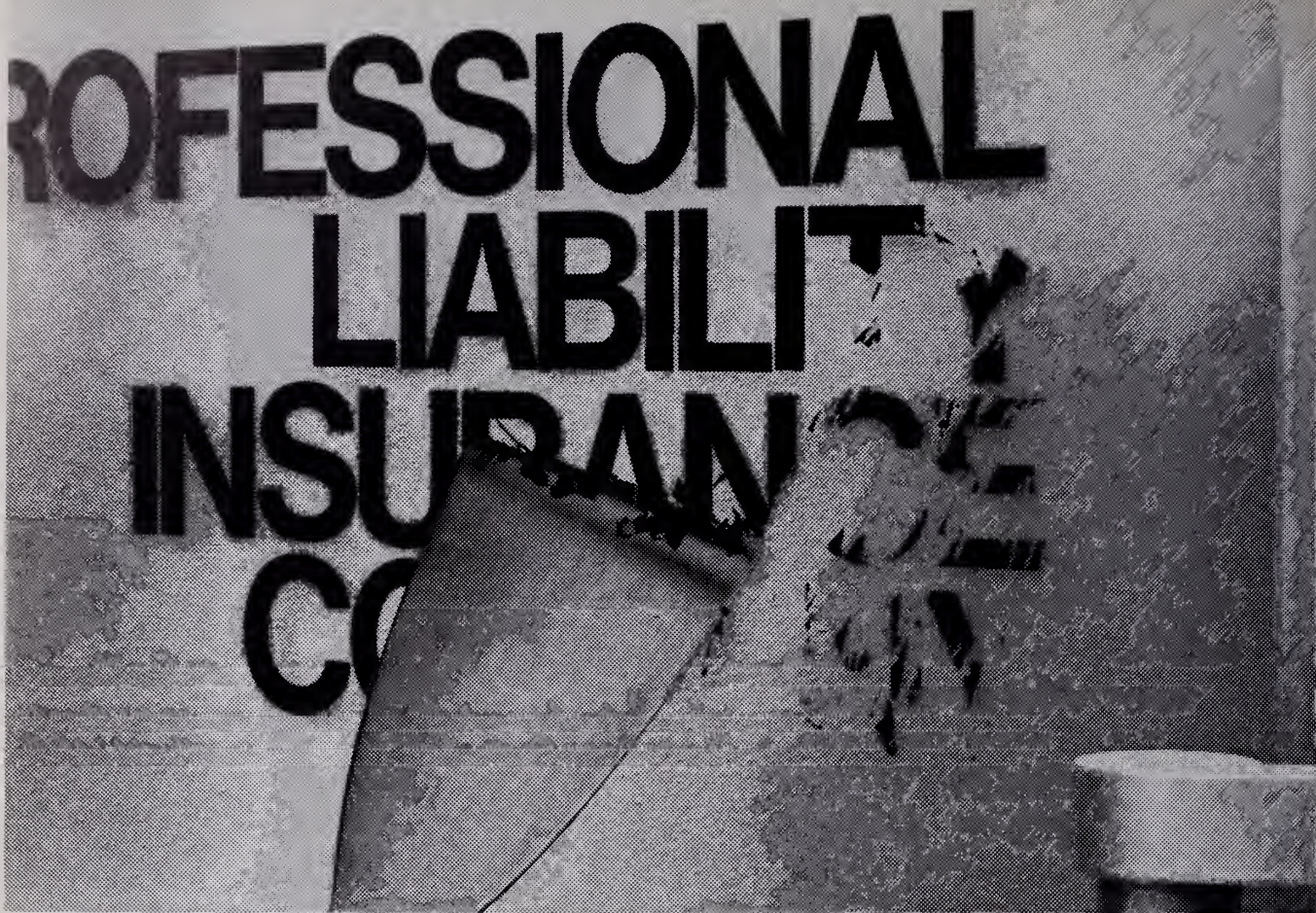
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COLLEAGUES

Marc Williams, MD, Medina, has been named medical director of the Society for Handicapped Citizens . . . **Andrew A. Detesco, MD**, a Boardman internist, has been named "Doctor of the Year" by the Mahoning County Medical Society . . . **Michael S. Hauser, MD**, Cleveland, has been named chief of the division of dentistry and oral/maxillofacial surgery at Mt. Sinai Medical Center . . . **Teymour Sepahbodi, MD**, Toledo, has been named director of the psychiatric unit at Blanchard Valley Hospital . . . **Roland W. Moskowitz, MD**, Shaker Heights, has received the Northeastern Ohio Chapter of the Arthritis Foundation's National Volunteer Citation Award . . . **J. Charles Garvin, MD**, Marion, has been named vice president of the Ohio MedCenter Foundation, the parent organization of the Community Healthcare Network . . . **David J. Garvey, MD**, East Liverpool, has been named director of emergency physicians at City Hospital . . . **Al Niemmer, MD**, a Middletown dermatologist, has been elected president of the Butler County Medical Society . . . **Richard Weinberger, MD**, Cleveland, has been elected president of the Cleveland Academy of Family Physicians . . . **Robert A. Wiltsie, MD**, Westlake, has been named vice president of medical affairs at Health Cleveland . . . 1988 officers for the Scioto County Medical Society are: **Ronald Arrick, MD**, Portsmouth, President; **Wayne Young, MD**, Wheelersburg, President-Elect; and **Suzann Bonzo, MD**, Portsmouth, Secretary-Treasurer . . . **Marino G. Ong, MD**, a Canton OB/GYN, has been installed as president of the Aultman Hospital medical staff . . .

Frank Vargo, MD, a Warren internist, has been elected president of the Trumbull County Medical Society . . . **John DiTraglia, MD**, Portsmouth, has been named medical director of Community Health Plan, Ohio region . . . **Robert Erickson, MD**, a Massillon orthopedist, has been named president of the Stark County Medical Society . . . **Ernest H. Meese, MD**, Cincinnati, has been elected secretary of the Ohio division of the American Cancer Society Board of Trustees . . . 1988 officers of the Mahoning County Medical Society are: **Hai Shiuh Wang, MD**, Youngstown, President; **Karl F. Wieneke, MD**, Youngstown, Vice President; and **Kimbroe J. Carter, MD**, Youngstown, Secretary . . . **Jerome A. Gans, MD**, Cleveland, chief emeritus of ophthalmology at Mt. Sinai Medical Center, has been honored by the American Academy of Ophthalmology on the 25th anniversary of his invention of automatic perimetry . . . **John R. Little, MD**, Cleveland, has been elected to the Congress of Neurological Surgeons' Executive Committee . . . **John P. Minton, MD**, a Columbus oncologist, has been appointed president-elect of the American Cancer Society, Ohio division . . . 1988 officers for the Lorain County Medical Society are: **Romeo Miclat, MD**, Elyria, President; **John Secrist, MD**, Elyria, President-Elect; and **William Jantsch, MD**, Lorain, Secretary-Treasurer . . . **Joseph Burns, MD**, Warren, has been elected president of Trumbull Memorial Hospital . . . **Joseph J. Macionia, MD**, Steubenville, has been elected to the Ohio Peer Review System's Board of Trustees.



Romeo Miclat, MD



John P. Minton, MD

Letters to the Editor . . . *continued*

AIDS testing . . .

continued

medical factors including medical testing may well be taken into account.

In summary, there are downside risks to having a positive HIV test, but *losing insurance in force* should not be included among those risks.

A. Robert Davies, MD
Representative for OSMA
Ohio Insurance Department
AIDS Task Force

Physician marketing

To the Editor:

Shame on the Journal of the OSMA! I read with interest and approval the first part of the article in the December, 1987 issue titled "Treating Your Practice — I." Then came the tips on paid promotions and advertising. You should have stopped after quoting the AMA guidelines on advertising.

The techniques you put forth

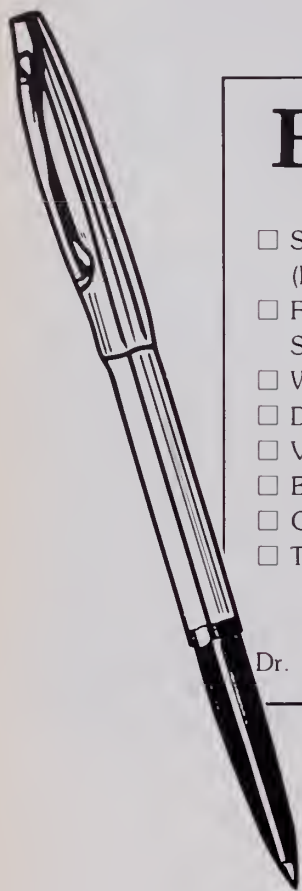
are demeaning to the *profession* of medicine. The fact that many physicians now advertise does not make it right — in spite of what the antitrust rulings may suggest.

As advertisers, we are no better than any other commercial enterprise, and the public has come to view medicine as a *business*. Need I say more?

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Editor's note: The following article was sent by the author to her patients. We are presenting it here in an editorial format.

Medicare Costs and Expenditures

By Sally Taylor, MD

To My Fellow Physicians:

Below is a copy of a letter I was compelled to write to my patients regarding Medicare costs and expenditures. As concerned citizens as well as physicians, it is becoming our increasing responsibility to educate our patients so they can intelligently express to Congress their dissatisfaction with programs that are limiting and counterproductive.

A recent article in the October 13, 1987 edition of the *Cincinnati Enquirer* regarding a new Medicare proposal has prompted my writing this letter. The constant implication that doctors as a group are responsible for the increasing costs of Medicare, and the emphasis on patients using government-selected physicians or be penalized is creating, for me, some real concerns. The greatest of these is the statement by the head of the Medicare agency, Dr. William L. Roper, that this proposal would "impinge on doctors' ability to

make decisions with respect to their patients." This translates to lesser quality care and frankly, this appalls me!

The figures given in the article show that Medicare spent \$76 billion last year, \$19.2 billion going to doctors. That leaves 75% of the Medicare budget going somewhere else, and I suppose I'm curious as to why this part of the budget is not selected for trimming. Unfortunately, the savings of \$50 million the first year and hundreds of millions per year in later years is somewhat misleading. Fifty million dollars is less than \$1.65 per person enrolled in Medicare, and less than 0.07% of the total Medicare budget. Even if \$900 million (if "hundreds of millions" can be saved later) adds up to less than \$30 per year per enrollee. This is not very much money if it means you give up not only your freedom to see who you choose and expect at least some reimbursement for that privilege, but also you give up the quality of care you've come to expect. In an attempt to find out if there may

be other answers, I reviewed statistics on health care and utilization in our elderly and made some interesting discoveries. Since 1950, the percentage of total health care paid to doctors has remained remarkably constant, at approximately 20%. Remember, this is *total* health care for any and all persons in our country, not just Medicare recipients. Since 1967, this holds true of Medicare also, with physicians being paid approximately 24% of total services reimbursed.

Of much greater interest was a table in the "Statistical Handbook on Aging Americans," 1986, regarding enrollment and reimbursements from 1982. Although I did not find a later analysis, I don't think the information would change drastically.

At that time, \$41.5 billion was spent on Medicare, and slightly less than 28 million people were enrolled. (For comparison purposes, 31 million is the number used in the *Enquirer* article.) Sixty percent of those enrolled were

reimbursed during that year, 1982. That means 40% *did not use Medicare* that year. Of this 60%, less than 4% used 47% of the total expenditures. In other words, less than 2.5% of the total enrollees in Medicare used almost one-half the money paid. That amount in 1982 used by 2.5% was \$19.5 billion, even more than was paid to *all* doctors in 1986. Of that total amount of money, \$29.2 billion was paid to those with hospital insurance, but even *fewer* people used their hospital insurance, i.e. only about 24%, and again, less than 3% of this 24% used 44% of this total. That means that less than 1% of the total enrollees spent \$12.8 billion.

And now, you are being asked to accept a very real infringement of your freedoms for a pittance.

You and I, as concerned citizens, whether on Medicare or not, need to let our representatives in Congress know that we are not satisfied with programs that impose restrictions, penalties and decreased quality of service for so little return.

An election year is approaching. If you agree that a different approach is needed, one that allows you to see the doctor of your choice, and receive quality care with no penalty, then write. I've included the names of our representatives in Washington. If you don't know what to say, send a copy of this letter and write "I agree" and sign your name.

We need to let those in charge know that we will not sit quietly and allow our freedoms to be eroded piecemeal with nothing in exchange.

If you have any questions, please call me. **OSMA**

Addendum: *In 1983, less than 10% of enrollees used 53% of Medicare reimbursements; this information is from the most recent statistical publication by the Health Care Financing Administration.*

Sally Taylor, MD, practices in Cincinnati.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine or the Ohio State Medical Association.

Correction

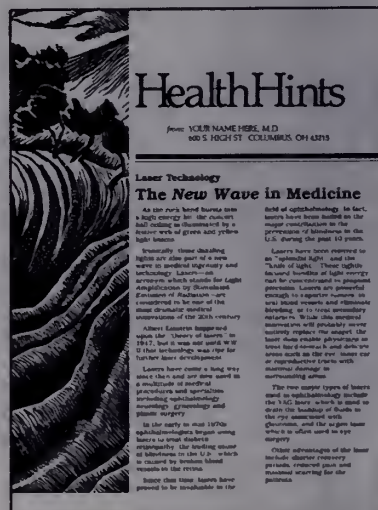
In the December issue of *OHIO Medicine*, the article "Laser Medicine: When You Need It, When You Don't" by Leon Goldman, MD, ran with two errors. In the section "Dermatology," the best treatment for a port-wine mark should have read the 577 nm. laser and not the 566 nm. According to Dr. Goldman, the 566 nm. does not exist today. Under the heading "Laser Neurosurgery," endoarterectomy was incorrectly spelled endurterectomy. *OHIO Medicine* regrets the errors.

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians



Older doctors . . . are they really best for older patients?

While it's true that older physicians spend more time per visit with older patients than younger doctors — and older physicians *are* likely to do more general examinations and provide more counseling than their younger counterparts — they may lag behind in providing other major services. At least, those are the findings of a new study, conducted by David B. Reuben of Brown University.

The study surveyed 1,800 doctors nationwide who were between the ages of 35 and 54 and those 65 and over.

According to the study's findings, older physicians are less likely to order mental-status tests, eye exams or prescribe physiotherapy for their older patients. They were also less likely to provide telephone follow-up of visits from patients over 75 and more likely to discharge office patients over 65 without any specific follow-up plan.

Reasons for these differences might be explained by a more informal practice or more intimate knowledge of patients, causing other physicians to make some clinical assessment without formal testing, says Reuben. However, the differences may also represent what he describes as a failure of elderly physicians to keep up-to-date with current concepts in medical practice.

The controversial report appeared, amid mixed reaction, in a recent issue of the *Journal of the American Geriatrics Society*.

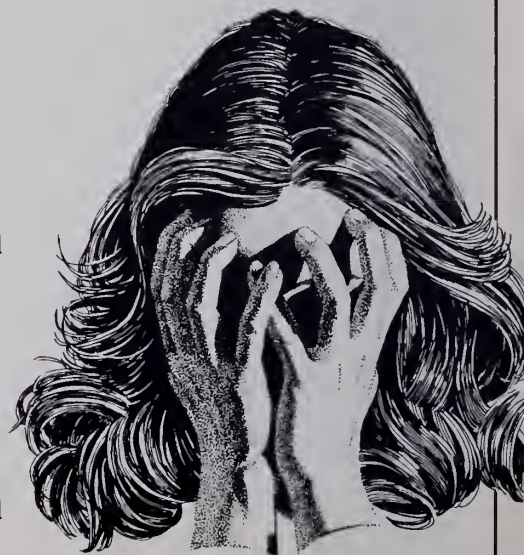
Patients prone to shame, humiliation

Patients who experience shame or humiliation in the doctor's office are not unheard of, yet little attention has been given to this important aspect of the physician-patient relationship, according to a recent report in *Archives of Internal Medicine*.

Shame and humiliation often enter into the picture because patients often perceive diseases as defects, inadequacies or shortcomings, writes Aaron Lazare, MD, of the University of Massachusetts Medical Center. The very nature of the office visit

— which requires physical and psychological exposure — only adds to the patient's stress, he notes.

By acknowledging that a problem exists, both patient and physician would benefit, writes Lazare, because "Patients respond to the suffering of shame and humiliation by avoiding the physician, withholding information, complaining and suing." Likewise, he notes, "Physicians may also experience shame and humiliation in medical encounters resulting in their counterhumiliation of patients and dissatisfaction with medical practice."



Pregnant women ignore warnings

Younger, less-educated women are more likely to smoke during their pregnancies than their older, more-educated counterparts, according to a government study recently published in the *American Journal of Public Health*.

Despite a number of campaigns warning women of the dangers of smoking while pregnant, the study reports that the number of white women under 20 who smoked while pregnant increased between 1967 and 1980.

Researchers from the



government's National Center for Health Statistics say the finding

may explain the incidence of low birth weights in the U.S. — a key factor that has stalled attempts to lower the nation's infant mortality rate.

During the 13 years in question, researchers found that the smoking rate during pregnancy among whites under 20 rose from 35 percent to 39 percent. The rate among young blacks, however, stayed the same — 27 percent. Smoking rates were reported highest among women who had fewer than 12 years of education, though the overall rate for that category dropped slightly, from 48 percent to 43 percent.

A new . . . and important . . . topic for conversation

Breast cancer is one subject most American husbands or "significant others" generally do not discuss with their partners. In fact, according to a recent nationwide survey, two out of three American men have never discussed mammography with their wives or partners, and less than half have discussed breast cancer or breast self-examination.

The survey also found that close to six in 10 men thought their wives examined their own breasts — a figure which differs greatly from a recent Gallup study which found that only one in three women perform breast self-examination.

To increase partner awareness in breast cancer and to open dialogue on the subject between men and women, the American Academy of Family Physicians, the National Cancer Care Foundation and the ICI Pharmaceuticals Group is sponsoring a nationwide campaign with Susan Ford Vance, daughter of former President and Mrs. Gerald Ford, as spokesperson.

The program, "A Partner's Guide to Breast Cancer Early Detection," outlines both what a partner should know about breast cancer and what he can do to encourage his wife or partner to take preventive measures.

Breast cancer will claim more than 41,000 lives this year. The sponsoring organizations of this nationwide appeal to men hope that by opening up the subject of breast cancer for discussion between husband and wife and men and women, early detection might lower this startling statistic.

Implantable hearing aid

A recent issue of *Archives of Otolaryngology-Head and Neck Surgery* includes what is described as the first report of human application of a partial implantable hearing aid.

Naoaki Yanagihara, MD, of the Ehime, Japan, School of Medicine, and colleagues say this middle-ear hearing aid uses a vibrator mechanism that is in direct contact with the stapes (stirrup bone of the middle ear). The vibrator picks up sound waves through an implantable amplifier attached to a tiny, implantable microphone.

At the time of the report, the patient, a 61-year-old man, had been using the device for more than a year. The authors noted that the "excellent frequency response of the vibrator and highly-efficient direct transmission of electroacoustic signals to the inner ear gave rise to acoustic perception of superior quality that could not be obtained by other surgical or rehabilitative means."



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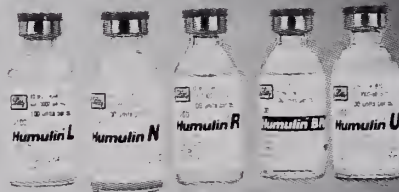
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OHIO MEDI-SCENE

Lawyers in medicine . . . AIDS update: cases, revised definition and research centers . . . Medicaid tips . . . malpractice in the psychiatry office . . . teenage depression

Lawyers learn a lesson in medicine

Cleveland-area attorneys eager to strengthen or expand their legal practices are taking advantage of the "Medical Institute for Attorneys," a series of medical seminars sponsored by the Cuyahoga Bar Association.

The eight-session program, which meets monthly through May, features eight guest physicians and is specifically designed for the attorney with a medical-legal practice, according to Pat McAulay, executive director of the association.

The seminars, she says, are meant "to educate the attorneys on medical areas that might enhance their practices."

While most of the discussions are fairly technical in nature, McAulay says "There are a lot of things (the average person) can understand. I can understand most of it."

The attorneys apparently haven't experienced any difficulties. "We've had a really favorable response from them," says McAulay, who adds that most of the attorneys specialize in workers compensation and personal injury claims, and are therefore familiar with many medical terms.



Guest speakers so far have included Elizabeth K. Balraj, MD, Cuyahoga County Coroner ("Forensic Medicine and Pathology"); Clyde L. Nash Jr., MD, Chief of Surgery at St. Luke's Hospital ("Orthopedics, the Spine"); Robert C. Corn, MD, Chief of Orthopedics at Huron Road Hospital ("Orthopedics, the Extremities"); Jerald S. Brodkey, MD, Chief of Neurosurgery at St. Luke's Hospital ("Neurosurgery and Pain Management"); and Mark D. Jacobstein, MD, Chief of Cardiology at Rainbow Babies and Childrens Hospital ("The Cardiovascular System").

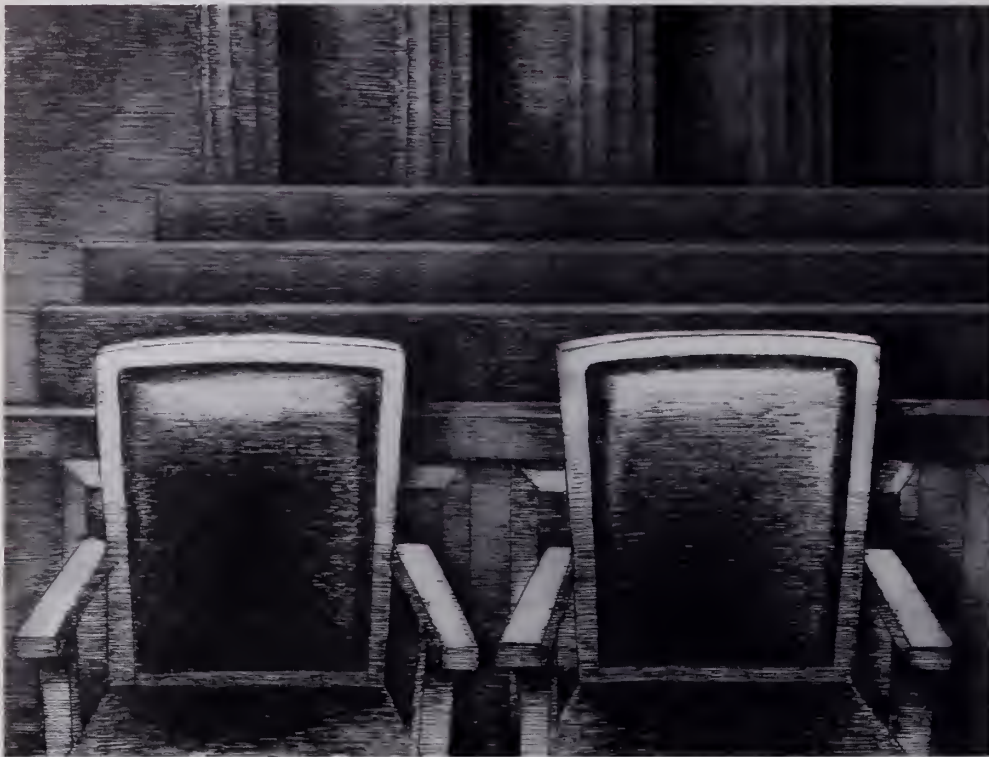
Dr. Balraj, the program's first guest speaker, says she attempted to show the relevance between the coroner's duties and the attorneys' practices.

"What I told them about was the functions of the coroner's

office," she explains. "We essentially discussed what they can expect from the coroner's office and how they can go about investigating their cases."

Dr. Balraj says she also touched on the importance of toxicology, forensic pathology and discovering trace evidence (such as jewelry and clothing), and reminded the attorneys that all records made by the county coroner are a matter of public record — something that could easily prove invaluable to an attorney investigating or preparing for a case.

Future speakers and their topics include Patricia M. Martin, MD, resident assistant clinical professor at Case Western Reserve University ("Psychiatry"); Earl J. Gleegler, MD, Head, Section of Hand Surgery at the Cleveland Clinic Foundation ("The Hand"); and David M. Weiner, MD,



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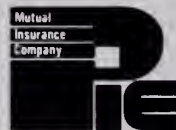
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Lawyers in medicine . . .

continued

associate clinical professor of pulmonary disease at CWRU ("The Pulmonary System").

Feedback from the participating physicians has been excellent, McAulay reports, and their enthusiasm has matched that of the attorneys.

"The doctors feel that the more contact between the two professions, the better." And that, she says, just goes to show "We don't always have to be adversarial." — *Michelle J. Carlson*

AIDS surveillance update: Ohio 1987

As the number of reported AIDS cases increases, so does the attention paid to the number itself. "The number" is perhaps the only piece of AIDS information consistently included in media reports concerning AIDS, regardless of the topic.

The case count comes from potentially thousands of individual reporting sources such as physicians and infection control practitioners (ICP) in hospitals and clinics across the state. These sources are the most critical link

in the surveillance network. Ohio physicians and ICP's are the backbone of the surveillance system.

Reports of all AIDS and ARC cases should be sent or called to the local health department of the patient's residence and forwarded to the ODH AIDS Unit. This same procedure should be followed for cases observed in residents from other states who come back to or through Ohio. A national surveillance network is in place and works very well to assure all cases are counted correctly according to their residence at onset. This network is also important in monitoring the mortality associated with AIDS, since persons with AIDS may expire in states or areas other than the one where their diagnosis was made.

The Ohio Department of Health believes AIDS surveillance in Ohio and throughout the U.S. is very good, especially relative to other diseases and conditions. Validating studies of existing surveillance systems across the nation have shown that ultimately as many as 85% to 100% of diagnosed AIDS cases will be reported. Such a validation study for Ohio is being done by the AIDS Unit to assess the completeness of reporting for the years 1984-1985. Preliminary data suggest approximately 90% of the cases diagnosed in those years were reported to the AIDS Unit.

Accuracy of the current incidence of AIDS, however, is not as complete. Largely due to delays at each step of the reporting process, some estimate that at any one time only as many as 60% of cases are actually included in the number of cases reported.

When the reports reach the AIDS Unit, names are coded to protect confidentiality and data are computerized and transmitted to CDC. The ODH AIDS Unit produces statistical updates

Medicaid tips

The Ohio Department of Human Services makes changes in the drug formulary quarterly.

Most additions and deletions are based upon recommendations presented by the Pharmacy and Therapeutics (P & T) Committee. The committee is comprised of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Waltenbaugh, RN; and Robert Reid, RPh, Chairman.

For your information, the following changes appeared in the January 27, 1988 Update.

Trade Name Additions

Cyklokapron 500mg, 100mg/ml; Desquam-E Gel 2.5%, 5%, 10%; Diasorb Tab, Liq; Elocon Cream, Oint; Abbott Erythromycin Caps 250mg; Fibercon Tabs; Grifulvin V 500mg; Humulin U; Hytrin 1mg, 2mg, 5mg; Levothroid 0.05mg, 0.175; Mefoxin 1gm, 2gm; Mevacor 20mg; Mezlin 1gm, 2gm, 3gm, 4gm; Mycostatin Pastilles; Normozide 100/25, 200/25, 300/25; Ocufen; Orudis 25mg; Parafon Forte DSC; Pronestyl Inj 100mg, 500mg; Proventil Repetabs 4mg; Rehydralate; Seldane 60mg; Theo-Dur 450mg; Trandate HCT

100/25, 200/25, 300/25; VePesid 50mg.

Generic Additions

Chloral Hydrate 250mg; Chlorzoxazone 250mg; Dacarbazine Inj 100mg, 200mg; Erythromycin Top Soln 1.5%; Fluphenazine Decanoate Inj 25mg/ml; Phenytoin Inj 100mg; 250mg; Senna Concentrate Tabs; Triamterene/HCTZ 50/25.

Deletions

Bronkosol Soln; Bufferin/Codeine; Cafegot Tabs; Diprolene Cream, Oint (To Be Re-Entered 5-1-88); Keflex 250mg, 500mg, 125mg/5ml, 250mg/5ml; Lopurin 100mg, 300mg; Niferex 150 Forte; Otcort; Pedialyte RS; Penicillin GK Susp 250mu; Pentids 200 Tab; Quinora 300mg.

Trade Name Readditions

Depakene 250mg; Dilantin 100mg; Mysoline 250mg; Tegretol 200mg.

To keep you informed of changes in the Medicaid Drug Formulary, your OSMA representative to the P & T Committee, Janet Bixel, MD, will be providing information as it develops.

OHIO MEDI-SCENE

AIDS surveillance . . . continued

monthly and disseminates thousands of copies to local health departments, hospitals, local task forces and others through numerous meetings and mailings. The data sheet for October is included in this newsletter.

The most interesting points to be made concerning this data sheet are that the total, 484 for October 1987, is exactly double that of October 1986. Even though the numbers have increased, the percentages in nearly all categories are reasonably consistent with those observed for several years, which reassures us that the disease is indeed not moving rapidly into other segments of our population and is not being transmitted by "casual contact."

providing valuable information about the ways in which transmission occurs. Surveillance data helps to identify areas where additional educational programs or support services should be directed, and serves as the basis for long-term health care planning and is often a key factor in the allocation of private and government funds. The number also serves as a grim reminder of the human toll of pain and suffering experienced by those it represents.

Realizing the importance of surveillance on so many fronts of our attack against AIDS we must, therefore, strive to keep numbers as accurate and up-to-date as possible. Though the reporting

developed in the early years of this decade has not been altered. The revision is perhaps more aptly called an expansion.

The two basic changes concern the addition of several more opportunistic infections and conditions, and the relaxation of the requirements for very specific means of diagnosis for several of the previously recognized infections and conditions. While these changes may result in a fairly sizeable increase in the number of cases counted as AIDS, we must understand and convey to the public the fact that this increase in number does not represent a sudden catastrophic change in transmission rates or patterns. In fact, by now using the revised definition we are not changing the size or shape of the "AIDS iceberg" of infection, but rather, we are lowering the water level to simply look at or count a bigger piece of the "iceberg."

Examples of conditions recently added include AIDS dementia, wasting syndrome, extra pulmonary tuberculosis, and CMV retinitis. Some estimate that an additional 10%-15% more cases will be counted due to these types of inclusions. Similarly, the relaxation of the requirement for some very expensive and invasive diagnostic methods will now allow physicians to presumptively diagnose certain infections clinically or with other less specific tests. This aspect of the revision may also result in another 10% to 15% increase in the number of cases reported.

Though the new case definition took effect September 1, 1987, the

Surveillance helps to identify areas where additional educational programs and support systems should be directed.

These numbers also serve to identify areas where greater educational efforts must be directed. This is most noticeably true for minorities who are disproportionately affected, and for adolescents who are experiencing an age of choices and decision making about sexual and drug use behaviors. A large number of those AIDS cases between the ages of 20 and 29 were potentially infected during their teenage years.

Surveillance is an important tool in our efforts to continue learning about the epidemiology and natural history of this disease,

process and forms often seem tedious examples of bureaucratic paperwork, the importance of both is obvious. — *Ohio Department of Health*

Case definition revised

The August 1987 supplement to the MMWR presented a major revision of the case definition used by the CDC for counting AIDS cases. This represents the first revision of the definition since 1985. Though some very important changes were made at this time, the basic underlying case definition

Case definition . . .

continued

impact of these revisions may not be seen in the number reported until early 1988. Both the CDC and the ODH AIDS Unit will continue to provide statistical updates of definitely and presumptively diagnosed cases. In addition, future cases will also be counted according to the 1985 revision in order to more systematically monitor trends in incidence.

For questions about the new case definition call the AIDS Surveillance staff at (614) 466-5480. — *ODH*

Ohio to get three AIDS research centers

The National Institutes of Health will be making experimental treatments for AIDS available in three Ohio cities, once federally-funded AIDS research centers can be established.

Columbus, Cleveland and Cincinnati are to be among 17 sites the NIH will set up nationwide to conduct research on AIDS, develop drugs, organize educational programs and administer government-approved trial drugs. Presently, 19 such centers are in existence.

Cleveland's University Hospitals, Case Western Reserve University (CWRU) and the Cleveland Clinic will work together as the study center for northern Ohio CWRU's School of Medicine will receive \$2.7 million

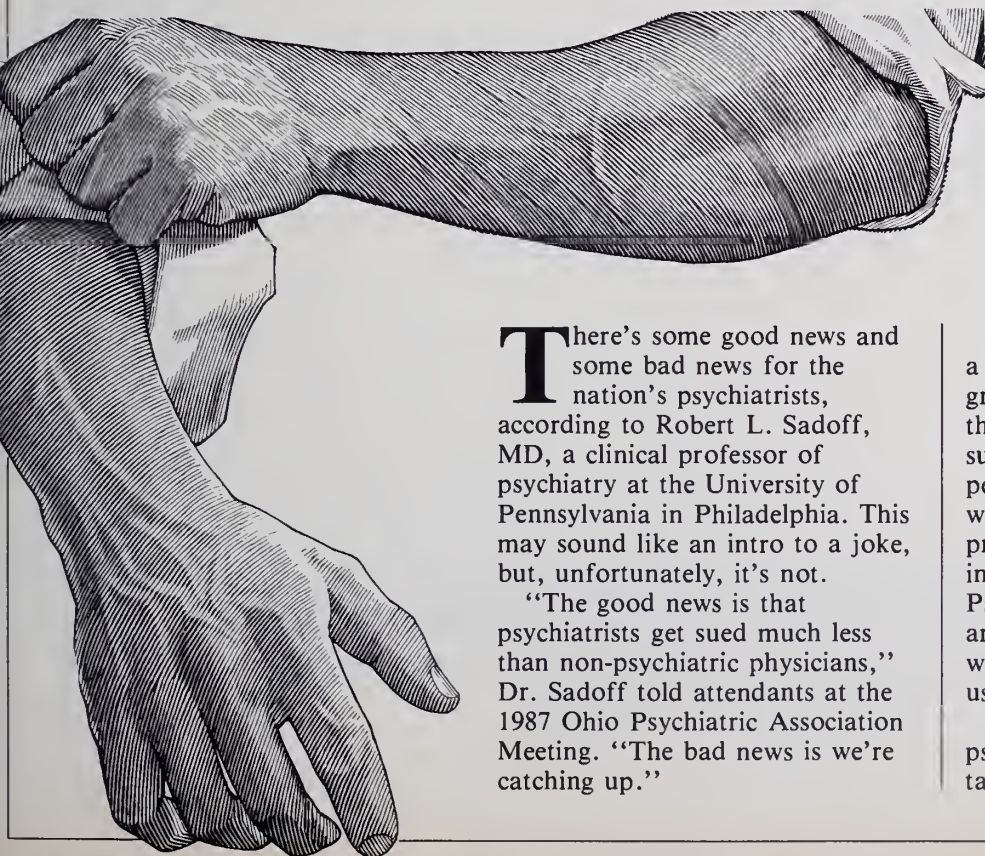
over four years for its clinical study of the experimental treatments for the disease. In addition, CWRU will receive a \$300,000 grant to study immune deficiencies and a \$7 million grant for the study of specific infections in AIDS patients.

Ohio State University in Columbus will receive \$7 million during the next five years to study new drugs for use against AIDS and to discover how the immune system reacts to infection.

The University of Cincinnati will also receive funds to establish a research center.

Presently, Ohio ranks 16th in the number of AIDS cases reported since June, 1981 with 529 cases reported (as of 11-2-87). Over half (62%) of these patients have died. — *Karen S. Edwards*

Malpractice muscles into the psychiatry office



There's some good news and some bad news for the nation's psychiatrists, according to Robert L. Sadoff, MD, a clinical professor of psychiatry at the University of Pennsylvania in Philadelphia. This may sound like an intro to a joke, but, unfortunately, it's not.

"The good news is that psychiatrists get sued much less than non-psychiatric physicians," Dr. Sadoff told attendants at the 1987 Ohio Psychiatric Association Meeting. "The bad news is we're catching up."

The image of the psychiatrist as a listening-and-talking expert is gradually becoming revamped in the public's eye, Dr. Sadoff suggests. The public increasingly perceives psychologists and social workers as the medical professionals who work primarily in psychotherapy and counseling. Psychiatrists, on the other hand, are seen as those professionals who treat only the very sick — usually with medication.

If this hypothesis is true, then psychiatrists are going to be the target of a growing number of

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PHYSICIANS



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Malpractice . . . continued

lawsuits, Dr. Sadoff predicts. It's been said before, but it bears repeating: If you have been a friend and listener to a patient, a lawsuit is far less likely to develop, he says. The more impersonal, business-like and anonymous the relationship, the more likely the subpoena.

The four D's that can spell doom for you and your practice? *Dereliction of Duty* that *Directly* leads to *Damage*, either economic, medical or psychological, Dr. Sadoff continues.

Dereliction — of duty doesn't mean that you have failed to provide top-notch care, but only that you have failed to provide a level of care considered "standard" in your community, he says.

"Recognize what the standard is in your community," Dr. Sadoff advises. "Don't practice beyond your expertise, call in a colleague when needed, and use informed consent."

Keep in mind that you are also responsible for the actions of your agents — of other professionals in your office, including nurses, medical assistants and receptionists. "The physician is seen as the acme, the high point of those in the office, with the highest financial position," he explains. You should instruct office members about confidentiality, for example, because you could be held responsible if information about a patient leaks out.

Dr. Sadoff offers the following ideas about a number of medical/legal issues that may affect your practice.

- Changing records. Another rule that bears repeating. Put one line through to change something and initial. Don't erase or paste over.

- Keeping records. The bottom line is: "If it's not in the record you didn't do it," says Dr. Sadoff. Don't make any assumptions — put it in the record. If you get a subpoena,

make a record of it. When you discuss treatment with a patient, make a record of it. Dr. Sadoff points out that you don't have to list all 200 side effects of a particular medication; you can write: "Discussed side effects with patient and we'll monitor them together." In short, Dr. Sadoff says, keep your records clean and straight.

- Informed consent. "We must give information to the patient about what we're going to do in language he or she understands and agrees to," he says. Deal with the information on the patient's level. Explain side effects, alternative forms of treatment, and effects of no treatment in understandable terms, he continues. "Give a reasonable menu of what to expect."

- Confidentiality is an ethical matter until it's breached. Once it's breached, it becomes a legal matter.

- Competency. The patient has

the right to refuse treatment if it is not an emergency and he or she is competent. A determination of competency is if the patient understands "the nature and consequence" of the illness.

- Misdiagnosis. If your reasons for a particular choice of treatment are known and charted in your records and the treatment is consistent, there is some room for different diagnoses, says Dr. Sadoff.

- Transference. A "classic" dilemma for psychiatrists dating back to the days of Freud and his young patient Dora. If you do become involved with a patient, stop making medical decisions about him or her, he emphasizes.

- Mistreatment. Inappropriate use of drugs that cause negative side effects, especially without informed consent, could constitute mistreatment. One more reason why informed consent is essential, for psychiatrists as well as for other physicians. — *Deborah Athy*

Tuning in to teenage depression

Society has almost come to expect a measure of malcontent in teenagers — whether it's in a spiky-haired punk rocker or the star of the high school football team. We've seen it in everything from "Rebel Without a Cause" to "The Breakfast Club."

"We bought into the idea that any psychiatric symptom falls within the realm of adolescence," affirms Sandra Sexson, MD, assistant professor of psychiatry at Emory University School of Medicine in Atlanta. "Some people tend to think *no change* in adolescents is abnormal."

But by making these generalizations about adolescent behavior, we may be pulling the wool over our eyes and missing some significant psychiatric symptoms, she points out.

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Teenage depression . . . continued

Speaking at the recent Psychiatric Update meeting, Dr. Sexson related an incident in which a young woman took a near-overdose of pills and claimed she did it by accident — a claim that her parents were ready to believe, she says.

Upon closer analysis, Dr. Sexson discovered that the young woman was in the midst of numerous changes in her life — her mother's recent remarriage, a move to a new home and plummeting grades in her new school. The near-overdose was a suicide attempt to gain attention, Dr. Sexson maintains.

"It is ironic that in the 20th century there is still the question of the existence of depression in childhood and adolescence. If the symptoms indicate a diagnosis, we should make it and act accordingly," she says.

Symptoms that may indicate depressive disorders in adolescents include:

- 1.) prolonged symptoms — for at least two weeks

- 2.) depressed mood
- 3.) loss of interest or pleasure, boredom, lack of enthusiasm, especially as compared to previous attitude
- 4.) change in weight
- 5.) sleep disturbances, as compared to prior sleep habits
- 6.) psychomotor agitation, such as picking hair, clothes or skin
- 7.) chronic fatigue
- 8.) excessive guilt
- 9.) concentration difficulties
- 10.) preoccupation with death.

Even in middle childhood and pre-school years, children may exhibit symptoms indicative of depression, such as separation anxiety, prolonged somatic complaints, school problems, and a tendency to be clingy and whiny.

Medical literature has begun to delve into adolescent depression again, opening up a Pandora's box of unanswered questions and obstacles, says Dr. Sexson. Several important hurdles to cross include:

- 1) a general denial of adolescent and childhood depression; 2) a

lack of agreement concerning diagnostic criteria; and 3) the difficulty in integrating developmental correlates in diagnostic criteria.

Other discussion touches on what extent social factors play in the development of adolescent depression. "Teenagers seem to be far more deeply touched by the threat of nuclear war than adults," she points out. "Suicide notes often refer to this."

Social factors may play a significant role and should be considered, but medical professionals also have to look at generation after generation of individual crisis of development in depression, she suggests.

Adolescent depression is a topic which generates more questions than answers, she admits. But the biggest mistake of all is to deny its existence. "Depression and bipolar disorders in adolescents are prevalent and require heightened suspicion for diagnosis," she concludes. — *Deborah Athy*

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SPECIAL FEATURE

Willingway: A Fellowship in Alcoholism and Drug Addiction





REPRODUCTION TECHNOLOGY

A Guide to What's Available in Ohio

By Karen S. Edwards

Medicine creating life in test tubes . . . making it possible to preselect the sex of a child . . . freezing, cloning, implanting eggs . . .

It sounds like a science fiction, or Orwellian novel set in the far-distant future, but, in fact, such actions are taking place today and with astonishing success. Is it playing God? That question is explored further in the articles that follow this and in those that will appear next month. This piece simply presents you with the facts — the type of technologies that are available here in Ohio for those infertile couples longing for a child.

It's difficult to say, of course, how many couples that is likely to be. Not all childless couples want children, of course. Yet, if we

assume that they do — and if we take into consideration the experts' estimate that 10 to 15 percent of all marriages are infertile, we're looking at some pretty respectable figures.

In 1984, for example, 98,700 marriages took place in Ohio. One year later, that number was down just slightly, with 94,373 Ohio couples tying the knot. In these two years alone, then, there were between 19,000 and 29,000 infertile couples in the state (if that 10-15 percent figure is accurate).

Help, however, awaits — in the forms and methods outlined below. With each method, we have provided you with a brief explanation of how the procedure is done, the extent of its availability — and the method's

present degree of success. We have also outlined the advantages as well as the disadvantages of each method, cited an approximate cost of the procedure (and whether or not it is covered by insurance, though few methods are), as well as listed any legal restrictions that may apply. Finally, to get you in the frame of mind for the four articles which follow, we hint at some specific ethical dilemmas each method creates. This is a broad look, then, at a very complex and constantly-changing field. Each listing has been based on interviews with Ohio experts in this area, and their names follow at the end of each item. *OHIO Medicine* thanks them for their assistance in preparing this guide. We hope you find it useful.

Gamete Intra-Fallopian Transfer (GIFT)

This method was introduced by San Antonio endocrinologist Ricardo Asche in 1984, and has gained rapidly in popularity with infertility specialists because of its very high success rate.

Pergonal, a potent hormone, or its purer form, Metrodin (which has only become available in the past six months) is administered to the patient during the first half of her cycle. The patient is then monitored daily through the use of ultrasound equipment until ovulation takes place. At that time, the eggs are "harvested" or removed from the ovaries and graded. The best four are transferred back to the woman's Fallopian tubes (two per side), and the sperm, properly washed and "dressed" in the material in which it would naturally appear, is artificially introduced. At this point, fertilization may occur, and a pregnancy result.

Extent of availability: The gamete-transfer, or GIFT procedure, has become widely available nationwide, and is currently available in about a dozen practices throughout Ohio.

Advantages: The biggest advantage gamete-transfer offers patients is a success rate of about 20-30%. However, the procedure offers other advantages as well. The procedure itself is a simple one to follow, although it does require a high degree of manual dexterity in surgery. It also allows women whose ovaries and Fallopian tubes are intact to conceive inside rather than outside the body. (Though that can also be deemed a disadvantage, since there is no way to tell whether or not fertility actually occurs.)

A new development that has recently begun to occur with the GIFT procedure is the forming of cooperative groups of women who

are willing to donate excess eggs, gathered during the laproscopic procedure, to women who are unable to produce a sufficient quantity (see sidebar story for additional information on the subject).

Disadvantages: The very nature of the GIFT procedure requires, of course, that the patient have intact both her ovaries and Fallopian tubes. If these are not present, the procedure cannot take place.

Also, since a powerful hormone is used to stimulate ovulation, the risk of multiple births is naturally greater than it would be during a normal conception, as is the possibility of an ectopic pregnancy.

Naturally, since some surgery is required to perform gamete-transfer, the same risks inherent with any surgical procedure — and the use of strong drugs — is also present. James Plunkett, MD, who pioneered the GIFT procedure in the Cincinnati area, has found patients are initially hesitant about the strength of the hormone given, but he says he likens its power to a Ferrari — dangerous in the hands of a teenage driver, but perfectly safe when it is in the hands of someone like Mario Andretti.

As far as the disadvantages to the physician, gamete-transfer does require a high degree of manual dexterity in the operating room, as already mentioned — as well as 24-hour a day availability, 365 days a year. Ultrasound equipment is also essential, and because of its high price tag, is not readily available to every practice. "As a result," says Dr. Plunkett, "it's quite possible that only three or four practices in a large town might be able to do the gamete-transfer procedure," says Dr. Plunkett.

Approximate cost: Varies greatly across the country, with large metropolises like Chicago and Los

Angeles charging \$6,000-8,000 (per cycle). In the Midwest, the fee usually runs between \$2,000-4,000, but most Midwest programs are generally restricted to area residents. Insurance companies presently do not pay much of the costs of a gamete-transfer procedure — about 10% is the average in Ohio — but as the experimental nature of the procedure gives way, and GIFT becomes a more acceptable therapy for the treatment of infertility, insurance companies may begin to pay more of the costs.

Success rate: 20% to 30%.

Legal restrictions: Detailed consent forms are necessary for the operation. Patients should also be made aware of the fact that the procedure involves strong drugs and can result in multiple births or ectopic pregnancy.

Ethical problems: "We can't escape the feeling we are interfering with the natural process of reproduction, the conception that takes place. We wonder how far it will lead," says Dr. Plunkett. "Despite a natural feeling of smugness that we can do it, and the altruistic belief that we are helping our patients, still, internally, doctors in this field have some reservations about what we are doing. I'm not as ethically torn with the gamete-transfer procedure, however," Dr. Plunkett continues. "I don't feel that I'm directing the play. God is. I'm just the taxi cab driver who is helping the actors get to the play on time, and I'm comfortable with that."

Prepared with the assistance of: James Plunkett, MD, Cincinnati.

Artificial Insemination

This method is one of the oldest solutions to the infertility problem, having been around now for three or four decades. AI, of course, is

A word about surrogate mothering . . .

used when the male has no sperm, low sperm or poor sperm — either as the result of a vasectomy, genetic disease or other factor — and, lately, the procedure has been gaining in popularity as more and more single women opt for pregnancy without benefit of spouse or “significant other.”

The procedure washes sperm, donated either from anonymous donors (AID) — (many programs use medical students as donors) — or from the patient’s husband (AIH) — possible because of increasing technology — and artificially introduces the prepared sperm into the patient’s uterus.

Extent of availability: Artificial insemination is widely available at fertility clinics throughout the state, and, to a lesser extent, at some private practices in Ohio.

Advantages: Before advantages can be discussed, it’s important to differentiate between AID and AIH.

As mentioned before, AID has only become possible due to increasing technology which can, to a certain extent, enhance sperm which have a low count, poor motility or other problem. If AIH can be used, the obvious advantage is that the resulting pregnancy will be the result of both biological parents. The technique, however, has a low success rate, a factor that will be covered under “disadvantages.”

Donor insemination, on the other hand has a high success rate (typically requiring only three cycles to pregnancy), and, of the two, is by far the most common procedure requested by couples who feel this choice is acceptable. For some couples, however, this is the *only* option available if the woman wishes to have a biological child — especially in those situations where the male partner has had a vasectomy. “In the cases I see,” says Jennifer Thie,

continued on page 187



The medical profession — at least in Ohio — is not comfortable, yet, with the subject of surrogacy, and with very good reason. The subject is rife with so many moral, ethical, legal and even medical problems that few physicians want to wander into this hotbed very far.

There are exceptions, of course. There is the East Coast physician, for example, who performs surrogate implants, transplanting the natural mother’s fertilized egg into another woman’s uterus. Since most surrogate births are conducted with the surrogate mother’s egg rather than that of the natural mother’s, surrogate implants are adding a brand-new dimension to the debate — as are the recent egg donor programs (see “Turnabout Donations”). A California physician, in fact, is flushing eggs from surrogate mothers and implanting them in infertile recipients.

“I know of no one in Ohio, however, who would touch the subject of surrogacy with a 10-foot pole,” says Jennifer Thie, MD, Director of Reproductive Endocrinology at Bethesda Hospital, Cincinnati.

Even the esteemed American Fertility Society was reluctant to

endorse the subject this past September, when it issued its ethical guidelines on new reproductive techniques. Surrogacy was the only negative viewpoint the AFS propounded.

And doctors aren’t the only ones holding back from the foray. At a panel discussion on the future of surrogate motherhood, presented at the Mandel Jewish Community Center in Solon last October, State Representative Judy Sheerer, quoted in the *Solon Times*, said that, although 19 states have proposed legislation on surrogate motherhood, Ohio is not one of them.

“Ohio doesn’t stand out as a pacesetter or innovator. We think the traditionally cautious approach is the best one to follow. The legislature is just not ready to consider the subject yet.”

Still, technology in both the area of genetics and reproduction is evolving to such a rapid extent that sooner or later, physicians (as well as Ohioans in general) will have to begin wrestling with their consciences and setting parameters.

In the meantime, however, the Ohio medical community is content to sit this issue out. —
Karen S. Edwards

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

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In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

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Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlorthalidone, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely.

A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only); and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) Injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG-L73B

Date of issuance Apr. 1987

SK&F LAB CO.

Cidra, P.R. 00639

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In peptic ulcer:

RELIEF REASSURANCE REWARD



Tagamet®
brand of cimetidine
First to Heal

You'll both feel good about it.

RESULTS

MD, a Cincinnati reproductive endocrinologist, "most couples have discussed it and have made the decision to go on to a donor." (after proper counseling regarding legal and psychological issues). The procedure is a relatively simple one, with few risks involved. "It's also less costly than adoption, and produces quicker results than waiting for a baby through an agency adoption," comments Dr. Thie. **Disadvantages:** Not so much a disadvantage as a concern is the screening of donors, which has become an extremely important issue in this age of AIDS and other transmittable diseases. This factor alone has forced some private practices to cease performing AI (unless they have access to frozen semen from a reputable donor bank). Most, however, are now referring cases to infertility specialists or clinics which have the manpower and funding to carefully screen donors.

Private practices are also at a technological disadvantage since few are able to afford the equipment needed to wash the sperm prior to its introduction into the uterus.

As far as disadvantages to the patient, the topic must again be broken into donor insemination and AIH cases. As already stated, the chances of pregnancy following the introduction of husband-donated sperm is very low. "You're starting out with abnormal sperm, so the technique is not as successful as when you're working with healthy sperm from an anonymous donor," says Dr. Thie. But that brings up one of the disadvantages of donor-donated sperm. "(AID) is more readily acceptable to the wife than to the husband," says Dr. Thie. As she explains, men often have to go through a grieving process — eventually coming to grips with the fact that they cannot produce

a child who is biologically theirs. "It takes some time to resolve those feelings and move on to other options," she says. Once they do, however, AID has proven to be very successful, especially in those cases where the woman has no infertility factors.

Approximate cost: Artificial insemination is probably one of the most inexpensive methods outlined here, costing about \$200-400 a cycle for donor-donated sperm, and about the same for husband-donated sperm. Since the average number of cycles to pregnancy (AID) is three, a patient can pay as little as \$600 — considerably lower, Dr. Thie points out, than most adoptions.

Insurance companies are often not involved in these cases, since the cost is relatively low, and couples frequently prefer anonymity. If insurance companies are involved, however, they are typically more sympathetic to AIH and AID cases. Some will cover up to 40% of an AIH bill.

Success rate: AIH — low, a 20% chance of pregnancy over six cycles. AID (and no infertility factors present) — 80% chance of pregnancy if only male factor is present.

Legal restrictions: An Ohio statute, passed in 1986, requires that AID must be done by or under the supervision of a physician who must, in turn, make certain determinations as to the medical history and laboratory tests done — and that holds true for both fresh and frozen donations. In addition, the doctor must obtain a specific written consent from the recipient (and her husband if she's married). If requested, the physician is also required to provide certain information concerning the donor (if known). Further, the doctor must note the date of the AI in his/her records and keep the consent form, as well as any other

information about the AI for at least five years — and, then, make sure it is separate from the patient's traditional medical chart.

The patient, for her part, must agree that there is no guarantee that she will become pregnant — or that, if she does — that the baby will be free of defects. She also agrees to allow the physician discretion in the selection of donor sperm.

Ethical problems: Religious beliefs are what make many people uncomfortable with the idea of AI — the thought that conception is being interfered with and will result in an unnatural pregnancy.

Other ethical situations are created in selecting the donor sperm — how should such choices be made, by whom, etc? Should donors be required to obtain written permission from their spouse? (Currently, no such requirement is made.) And, of course, a whole Pandora's box of ethical dilemmas has been created with the recent interest expressed in the procedure by single women.

Many of these issues have already been discussed in depth, with no generic solution resulting. Still other issues have yet to be faced.

Prepared with the assistance of: Jennifer Thie, MD, Director of Reproductive Endocrinology, Bethesda Hospital, Cincinnati.

In Vitro Fertilization

An older procedure than GIFT, in vitro fertilization has helped many women conceive when the possibility seemed remote. Although women whose ovaries and Fallopian tubes are still intact are now turning more frequently to the GIFT procedure (some place this figure as high as 75%), experts say that the in vitro fertilization technique will not be replaced.

continued on page 189

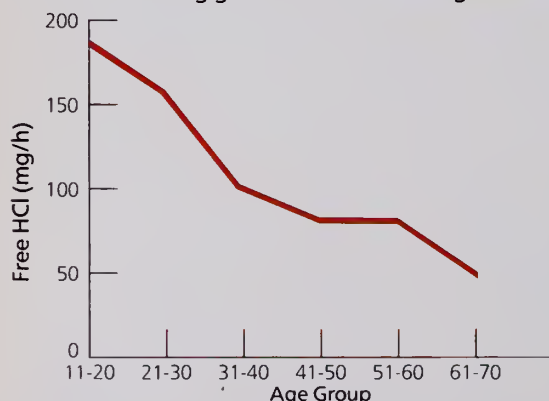
Specialized ulcer therapy

When advancing age signals reduced acid secretion



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Please see adjoining page for references and brief summary of prescribing information.

1595H7



BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

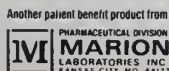
While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

1. Grossman MI. *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellems J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly*. Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellems J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly*. Edinburgh, Churchill Livingstone, 62-69, 1984.



1595H7

Reproduction Technology . . . continued

"GIFT is not an option for the woman with abnormal tubes," says Dr. Thie. "In vitro fertilization is."

As in the gamete-transfer procedure, the patient is stimulated, through use of a potent hormone, to produce eggs which are gathered during a laproscopic procedure. These eggs are not transferred directly to the Fallopian tubes, but instead are introduced to the husband's sperm in the laboratory, outside the woman's body. Then the embryos are transferred to the woman's uterus.

Extent of availability: In vitro fertilization is widely available throughout Ohio, but primarily at fertility clinics as opposed to private practices.

Advantages: As mentioned, the advantage in vitro fertilization has over the GIFT procedure is that it offers those women whose Fallopian tubes are blocked, abnormal or damaged an opportunity for pregnancy. There is also the advantage that fertilization is known to occur with the in vitro process, since that step takes place in the laboratory. With the GIFT procedure, fertilization takes place inside the patient's body, so that factor remains obscure unless pregnancy occurs.

"We had one patient who had tried the GIFT procedure and could not get pregnant," says Dr. Thie. "We didn't know why, so we used in vitro — fertilizing the eggs before implanting them. It worked."

Disadvantages: The success rate for in vitro fertilization is not as high as the success rate for gamete-transfer procedure, yet it carries the same surgical risks for the patient. That prompts Dr. Thie to urge caution when either patients, or doctors looking to refer patients, consider a fertility clinic.

"They should try to get a success rate from the clinic, both in terms of an ongoing pregnancy rate and a sustained pregnancy rate," she says.

As with the gamete-transfer procedure, multiple births may also prove to be a problem since, once again, Pergonal and Metrodin are used to stimulate egg production.

"Hyperstimulation can be a problem, causing big cysts to form on the ovaries. Removing the eggs seems to prevent the problem from occurring," says Dr. Thie.

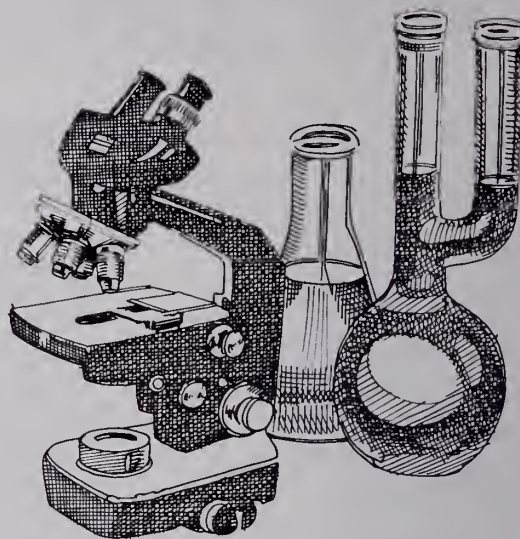
Approximate cost: Generally, costs for in vitro fertilizations run about \$4,000-7,000 per cycle. The Mayo Clinic, for example, charges about \$6,000, but in California, the cost for one cycle can be as high as \$10,000. Here in Ohio, the technique typically runs about \$4,200 per cycle, although some programs in the state are being subsidized by local funds, which can lower the costs by about \$1,000. A separate charge of about \$500 for the drugs may also be included in the final bill.

As with most of the procedures mentioned here, insurance is not picking up much of the costs, though some companies may pay for parts of the bill.

Success rate: Rarely does the success rate reach the astounding 30% purported by the gamete-transfer procedure. Usually, in vitro patients can expect a 20% success rate or, more typically, a 19% success rate — which seems to be the nationwide norm. Compare both rates, however, with a couple's natural chance of getting pregnant in a given month — about 20-25%.

Legal restrictions: As with the gamete-transfer procedure, detailed consent forms are required for surgery and the patient should be informed about both the drugs that are used and the risks of multiple births.

Sex preselection is said to increase the chances of delivering a boy or girl (whatever is desired) to 80-20 odds.



Ethical dilemmas: The ethical situations created by in vitro fertilization are essentially the same problems which confront all fertility specialists — the sense of interference and “where will all this lead?”

Different religious beliefs also have difficulty accepting fertilization taking place inside a test tube.

“The problem is that patients are often confused about what procedures are acceptable (by the Catholic Church) and what is not,” says Dr. Thie. “The diocese here has appointed someone to receive calls and systemize the information, but there is still a confusion.”

Prepared with the assistance of: Jennifer Thie, MD, Cincinnati.

Sex Preselection

Sex preselection is a method that has only come to the Ohio area in the past year, although Ronald Ericsson, PhD, pioneered the method during the early 1970s.

The technique enhances the preponderance of X or Y-bearing sperm by using albumin filtration if a male is desired or by filtering through sephadex gel if a female is preferred. To explain the method in more detail . . . the sperm is layered over vertical columns of concentrated albumin (or gel), and the sperm swim down to the bottom of the tube.

The technique is said to increase the chances of delivering a boy or girl (whichever is selected) to 80-20 odds. Under natural conditions, the chances of delivering a male are said to stand at 51%; a female, 49%.

Once the sperm has been filtered, it is artificially inseminated into the patient's uterus.

Extent of availability: Presently, only one practice in Ohio offers sex preselection, but chances are good that this number will increase over the next five to 10 years. Sixty centers now offer sex preselection nationally (up from the 1986 total of 40), and 12 other centers are located outside the U.S. (up from seven).

Advantages: The primary reason most couples seek sex preselection is demographics. “Most of the couples I see are those who are greater than 25 years old, middle-class, and who have a family already but want just one more child,” says F. Bruce Watkins, MD, an OB/GYN who offers sex preselection to patients in his Dayton practice. These couples are usually hoping for the boy or girl they never got, and come to Dr. Watkin's office to increase their chances of delivering what they want. There is another, sometimes overlooked advantage to the preselection method — there *are* cases where, due to genetic factors

or other medical problems, it is clinically desirable to produce either a son *or* a daughter. In these situations, sex preselection offers obvious advantages.

Disadvantages: The same risks that are involved with artificial insemination are present with sex preselection. Generally, risks are minimal, but the introduction of an infection to the uterus is one danger to which patients are alerted.

Approximate cost: \$400 per insemination. “The first two pregnancies occurred after the first insemination,” says Dr. Watkins — but he adds this is more the exception than the rule. Typically, pregnancy is achieved after three to four cycles. National figures suggest 10% pregnancy rate per insemination, about one-half the success of natural insemination.

Success rate: National statistics quote 80% success rate for choosing males; 72% for choosing females. Still, Dr. Watkins tells couples that nothing is guaranteed (the method doesn't work for everyone), and those couples who insist on a boy or a girl are discouraged from participating.

Legal restrictions: “There are none that I am aware of,” says Dr. Watkins, other than the typical informed consent forms.

Ethical problems: According to

continued on page 193



The World's Most Popular K*

Slow-K[®]
potassium chloride
slow-release tablets
8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

The World's Most Popular K

For good reasons

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- **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient¹



Slow-K®
potassium chloride
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiaro SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiaro SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K®
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mL of 10% dextrose solution containing 10-20 units of insulin per 1,000 mL; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K).

Bottles of 1000	NDC 0083-0165-30
Consumer Pack—One Unit	NDC 0083-0165-40
12 Bottles—100 tablets each	NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)	
Box of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

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C87-31 (Rev. 8/87)

C I B A

128-3568-A

Turnabout donations

For nearly 40 years, donated sperm, artificially introduced into a woman's uterus, have enabled formerly childless couples to produce an offspring. Now, it's the woman's turn.

Thanks to recent advances in the field of cyropreservation, eggs and embryos removed from a woman's ovaries may be successfully frozen, then later implanted into an infertile woman's reproduction system.

Because in vitro fertilization and, more recently, the gamete intra-Fallopian transfer technique can make use of frozen eggs (and/or embryos), movements have recently begun to enlist egg donors, much the same way that, for years, men have been recruited to donate sperm.

In fact, the first formalized program in the nation was introduced last year at the Cleveland Clinic by Martin M. Quigley, MD, director of the Clinic's in vitro fertilization and embryo replacement program. Women between the ages of 18 and 35 are recruited as donors (married women need their husband's consent), and in return,

donors receive from \$900-\$1,200 for their participation.

By late summer, 75 couples had indicated an interest in the program and 50 had already undergone some of the extensive physical and psychological screening required by the Clinic. Anonymity was — and is — a factor the Clinic insists upon. The donor cannot be related to or know the recipient.

At the other end of the state, a similar program, though one far less structured in nature, is in the planning stages. James Plunkett, MD, who practices the gamete intra-Fallopian transfer technique in his Cincinnati office, tells of their plans for an informal "cooperative" group of women who may donate any excess eggs gathered from their ovaries during the laproscopic procedure. Since the powerful hormones given to patients prior to "harvesting" stimulates egg production, often more than the four eggs needed for the GIFT procedure are gathered.

"We are planning to give the women the opportunity to donate the excess eggs to help someone

who may be having trouble producing them," says Dr. Plunkett. Despite the fact that there is no financial compensation for the donation, many women are agreeing to donate, knowing from their own experience the difficulty some women have becoming pregnant. "They will donate knowing that they may be able to help someone like themselves," says Dr. Plunkett.

The procedure, however, is not as simple as sperm donation, and there, according to some reports, lies the ethical rub. Gathering eggs from a donor requires a surgical procedure — with all the inherent risks attached — and, obviously, some people will question the necessity of such risks.

Also at question is the ownership of the eggs. What determines parenthood? Should the donor have rights — and, if so, what should those rights be?

Such questions merely serve to add yet another dimension to those ethical debates on reproduction technology already in progress. — *Karen S. Edwards*

Reproduction Technology . . . *continued*

Dr. Watkins, the ethics of sex preselection have been "blown out of proportion."

"We are doing the same thing that nature is doing," he claims, pointing out that the body sets up its own preselection system by establishing any number of hostile environments for the sperm. The filtering system used in sex preselection is merely copying nature by presenting barriers to either X or Y-bearing sperm, thereby changing the concentration of sperm that eventually reaches the egg.

"The other complaint I've heard," says Dr. Watkins, "is that sex preselection will create a huge influx in the male population, but that's not true. This method has been around for 10 years and claims only 600 births. Not everyone wants boys, of course, and not everyone wants — or can afford — to make a choice. Besides, as has already been pointed out, the method is not foolproof.

"Of course any method developed by man is less successful than the method done naturally,"

points out Dr. Watkins. "The natural process (of conception) has evolved over millions of years. It's perfect." Man-made methods need time to catch up.

Not everyone believes, however, that sex preselection is a method that should be used at all — outside of those few cases where it may be clinically indicated. It's an area that continues to be discussed in ethical as well as medical circles — and one that probably will be for some time.

Prepared with the assistance of: F. Bruce Watkins, MD, Dayton.



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Reproduction Technology: Cataloging the Criticisms

Editor's Note: This month, *OHIO Medicine* presents the ethical dilemmas of reproduction technology as viewed by an ethicist and an appeals court judge. Next month, two physicians present their views.

An ethical view

By Peter Horn

Reproductive technology is a highly charged phenomenon. It forces us to examine and rethink many of our most strongly held values and basic concepts: life, death, sex, family, medicine, science, freedom, gender roles and the nature of the human species. Discussions of it often blend philosophizing, science fiction speculation, theological pronouncements and armchair sociology. People have voiced numerous objections to reproductive technologies. In what follows, we'll survey the technologies and some of the main criticisms of them. Along the way, I'll venture a few comments about those criticisms.

The technologies

First, we should get an idea of the scope of reproductive technology. It includes methods such as contraception,

sterilization, abortion and many of the techniques and devices currently used for obstetric purposes. It is important to keep this in mind, since many of the ethical issues and criticisms about the less established methods have arisen in connection with these as well. Nevertheless, a number of new problems and dilemmas have been created by the more exotic technologies with which we are mainly concerned here. Some of the new technologies already exist; others do not. Some may be used in conjunction with others.

1. Artificial insemination (AI), a widely used method, has several forms: artificial insemination by (anonymous) donor (AID), artificial insemination by husband (AIH), and "confused" artificial insemination (CAI), in which the sperm of the husband is combined with that of a donor to increase both the sperm count and the husband's feeling of contributing

to the process.

2. According to recent reports, a method has been devised that sorts sperm into male and female with 90% reliability. That makes possible preselection of the child's sex. Until now, the only way of ensuring that the child would have the chosen sex was to perform amniocentesis and then, late in the second trimester, to abort the unwanted fetus.

3. In vitro fertilization (IVF) with embryo transfer has produced babies for a decade now. A variation of this uses donated eggs if the fertilization was initially impossible because the recipient was infertile because of inability to produce eggs.

4. In vitro gestation remains in the realm of speculation. Fetal life cannot yet be sustained extracorporeally beyond a limit of prematurity. In principle, though, viability could continue its present trend toward conception.

To accept all new technologies without question would be a mistake, just as is the condemnation of those that represent novelty or that test the boundaries of our ideas and opinions.

5. Surrogate pregnancy, also called surrogate motherhood, has generated a storm of debate. Much of the argumentation has focused on the Baby M case, a case currently under appeal in New Jersey.

6. Frozen embryos enable people to conceive when they wish and then to raise the child some years later when they choose to. This is still comparatively rare.

7. Prenatal diagnosis is important. Antenatal testing of various sorts has become a valued part of much obstetric care.

8. Cloning at this point is only a science fiction project if one is thinking about the human species. It is commonly done with other species, however, particularly with bacteria and plants.

9. Fetal surgery and other treatments such as intrauterine transfusion for severe Rh anemia are being performed increasingly.

10. Various types of genetic engineering using recombinant DNA still don't apply to human reproduction. This leads to the next topic, though.

11. Eugenics is the selective breeding of humans. It has been advocated both by people with constructive goals and by others with sinister, frightening intents. To attain some clarity about this area, one should distinguish positive eugenics (breeding in good traits) from negative eugenics (breeding out bad traits), and voluntary vs. coerced eugenics. Most people would find voluntary negative eugenics much more acceptable — or less questionable — than mandatory positive eugenics.

Criticisms

A number of ideas and themes come up often during discussions of many of these technologies.

1. **Scenarios.** A reproductive technology may be condemned on the grounds that it would (or *might*) lead to a Brave New World or to a Nazi-like society or an all-male society or to an army of Frankenstein-like monsters or zombies. In order to assess these scenarios, one needs to hear more about the specific scenario and the *evidence* that the feared outcome will occur.

2. **Familicide.** Another frequently expressed criticism is the claim that a reproductive technology will cause, or at least contribute substantially toward, the demise of the parent-child relationship, and hence to the end of the family. Loss of the institution of the family, in turn, will lead to the decline of civilization or the destruction of the moral fabric of society. While I doubt that anyone would endorse the tearing of society's moral fabric, it should be noted that to change the method of reproduction, perhaps to add new types of (biological) families is not necessarily to change what is most valuable about the family. It is, I think, a *factual* question whether any given form of reproductive technology will actually increase, decrease or leave unaffected the amount of love and stability in families.

3. **Artificiality.** A further criticism says that there is a natural way and an artificial way to do something and only the natural way is acceptable. If that

were true, then no medical technology would be acceptable.

4. **Depersonalization.** Others maintain that use of a reproductive technology diminishes human dignity or personhood or uniqueness or individuality. The criticisms may have merit, depending upon whether one can make clear in what sense of "dignity" the technology in question threatens dignity, and also why it is assumed that the technology threatens dignity, personhood, uniqueness or individuality.

5. **Uncertainty.** A different line of criticism argues from uncertainty. According to it, a technology has been insufficiently tested. We don't yet know what will become of that technology in the long run, the critic maintains. Concerning some technologies such as cloning of humans or positive eugenics or *some* recombinant DNA, caution seems well-founded. Other technologies, however, have been adequately tested and shown safe and effective.

6. **Illegality.** Some argue from the current legal structure. They assert that the law presently has no provisions for situations like those arising from a particular reproductive technology. This is among the weakest criticisms. If the law needs to be changed, then it should be. A more subtle argument questions whether the acceptance of a new technology might (or is it *would?*) set a bad precedent that could or would have harmful effects.

7. **Feticide.** Depending upon the technology in question and the

view of the fetus' moral status, some people claim that many fetuses are unnecessarily or unjustifiably destroyed, for example by being discarded after in vitro fertilization or as a result of abortions following decisions made on the basis of prenatal tests. The issue of the fetus' moral status has proved exceptionally difficult.

8. Exploitation. Some label as exploitation the use of certain technologies such as surrogate pregnancy. They say that the method treats women as mere commodities, that it takes advantage of them. They think it will result in the creation of a group of women who are breeders. Feminists and others are deeply divided about this criticism and about surrogacy in general. While many women are and have always been at risk of being exploited for their reproductive capacities, it is not clear that many more would suddenly fall into that class as a result of opportunities for surrogate pregnancy. The women who go through surrogate pregnancy would do so by their choice — seemingly no more exploited than those who work in factories, fields or offices — and would be fairly well paid for their service. Many women are coerced, manipulated or deceived into pregnancy by their husbands or partners and must also work at a mind-numbing or physically taxing job for meager pay. They qualify as exploited people. Interestingly, that exploitation's legality hasn't been challenged.

9. Wasteful. Some contend that a specific technology involves wasteful use of resources. Why spend many thousands of dollars, they ask, rather than using much less expensive, more traditional methods? Medical resources, they argue, should be more effectively allocated. Most people would agree that resources might be

better allocated, but two questions must be asked about this. First, *if* a given reproductive technology (in vitro fertilization, for example) were prohibited in the name of allocation, would the money saved be reallocated toward humane, inexpensive, cost-efficient programs? Since most of the new technologies are not government-funded, it seems that the answer to that question is no. Secondly, do we really want to outlaw any technology that is a luxury or wasteful? That means an end to new cars and VCRs. This leads to the next criticism.

10. Not therapeutic. A technology isn't therapeutic at all, but rather mere satisfaction of wants or whims, and so not the proper function of medicine. It treats desires rather than diseases. This criticism may well assume what it should show: that is, that reproductive technology is wrong unless used to cure disease. Why assume that medical activities, in order to be morally acceptable, must be used exclusively to cure diseases? Do the proponents of this view also assume that technologies generally may be used only to eliminate suffering? If not, then why single out *biological* technology? Furthermore, treatment for infertility due to dysfunction of the reproductive system is a disorder, and the prevention of serious congenital anomalies and hereditary diseases and conditions is therapeutic.

11. "What-ifs." "What-ifs" constitute another class of criticisms. Some are more plausible than others. Here are some examples: What if a child produced in a surrogate pregnancy has abnormalities, or turns out to be twins, or what if people change their minds, or something else goes wrong? There can be no blanket responses to these objections. They must be considered individually. But in

each case what we must decide is whether the *possibility* of a problem precludes the acceptability of the technology in question. A technology that would change the entire species drastically and irrevocably merits much more caution than one which effects a much more subtle, individual change.

To accept all new technologies without question or reservation would be a mistake just as is the uniform condemnation of those that represent novelty or that test the boundaries of our ideas and opinions. We're increasingly encountering future shock from the multitude of new reproductive technologies. As is recognized in medicine, though, shock can be traumatic or it can be therapeutic. **OSMA**

Peter A. Horn, PhD, is an ethicist who teaches ethical issues at Mt. Carmel School of Nursing and Ohio State University and is a member of the faculty on the Department of Religion and Philosophy at Capitol University, Columbus.

Next month in OHIO MEDICINE

- The program for the 1988 OSMA Annual Meeting
- Reproduction Technology: Cataloguing the Criticisms — Part II
- Ohio's Medicaid Drug Formulary: What You Need to Know.



Oscar W. Clarke: “A Doctor’s Doctor”

By Michelle J. Carlson

When word came in early December that Oscar W. Clarke, MD, had been appointed to the American Medical Association’s Council on Ethical and Judicial Affairs, the OSMA didn’t lose a longtime delegate to the AMA. It gained a valuable voice in shaping national ethical guidelines for organized medicine.

“We’re not losing anything,” says OSMA President D. Ross Irons, MD. “We’re going to gain because he’s been named to a higher position. He’s still working

for his patients. He’s still from Ohio.”

When Dr. Clarke, an internist from Gallipolis, was appointed to replace the late David I. Olch, MD, on the nine-member committee, he subsequently relinquished his position as chairman of the Ohio Delegation to the AMA as well as his position as OSMA Delegate to the AMA. And while Dr. Clarke is sure to be missed — he had served in that position since 1972 — Dr. Irons says he is confident Dr. Clarke is well-suited to his new role.

“We will probably examine the impact of technology on ethical decisions in medicine, and that will include reproductive technology, gene probes and gene manipulation.”

“Of course I approve of his appointment,” says Dr. Irons. “He’s a doctor’s doctor. He’s ethical, he’s hard working, he works for his patients.”

After talking with Dr. Clarke — himself a former OSMA President (1973-74) — it’s obvious he is pleased with his appointment. Still, he is careful to credit his supporters — friends and colleagues who backed him when he first learned he was being considered for the prestigious position.

“I’ve never,” he says, “had such an overwhelming show of support before in my life.”

On the surface, Dr. Clarke is an affable man — warm, friendly, more than willing to answer your questions. Ask him about the importance of Council, however, and his tone immediately becomes a mixture of enthusiasm and concern.

An emphatic “Yes,” for example, is his response when asked if the Council is currently studying any “big” ethical dilemmas in medicine. “Oh my goodness, yes. We just issued a report on AIDS,” he says by way of example, “(the) one that says it’s unethical for a physician to refuse to treat an AIDS patient.”

AIDS, he continues, is apt to remain a major concern of the Council’s for some time, mainly because “a number of problems are coming up. What we will try to do is put out a report regarding the ethical issues involved in AIDS — and there are *a lot* of them.”

Other issues he predicts will be continuous sources of debate: the conflict of interest that arises when a physician refers a patient to a hospital or clinic that the physician holds a financial interest in; the ethics surrounding the procurement of infant tissues and organs for transplant (as was recently demonstrated in a California case involving an anencephalic infant); and surrogate mothering.

“Ethics,” Dr. Clarke reminds us, “concerns all of these things.”

Looking further down the road, Dr. Clarke predicts the Council will focus intently on several issues — the “biggies” to use his own words — that will likely be tossed around and debated for years.

“Sometime in October,” he says, “we will probably examine the impact of technology on ethical decisions in medicine, and that will include reproductive technology, gene probes and gene manipulation.” The Council, he says, will probably conduct a two-day conference devoted solely to these issues. “It’ll be a scientific look at where we are with these things.”

Because the Council, which was officially renamed in 1985 (it previously existed as the Judicial Council), has never had a set schedule per se, it can therefore consider a number of different ethical issues at the same time.

“We can generate our own agenda and come out with a ruling,” Dr. Clarke explains. “We also receive suggestions from outside sources.

It depends on the urgency of the situation. If it’s urgent enough, we’ll meet and discuss it.”

As a newcomer to the committee, Dr. Clarke has yet to suggest topics for discussion. “I have a whole lot of (issues) in my mind,” he admits, “but that doesn’t necessarily mean Council will take them up.”

With such an illustrious career behind him — Dr. Clarke has served in literally dozens of professional and civic capacities — it would be easy for Dr. Clarke to rest on his laurels. But he views his appointment — indeed, the entire Council — as having too important a mission to be taken lightly.

“I’ve been dedicated to organized medicine since Day 1. It’s part of my dedication to the profession,” says Dr. Clarke. “In medicine, the ethical issue is nearly as important as the scientific issue. We have to keep our ethics as we advance scientifically. It’s a part of morality, and any civilization that’s going to succeed is going to have to preserve its morality.”

If Dr. Clarke’s words are any indication of what he plans to impart upon the Council in the coming year, organized medicine can rest assured that it’s in capable hands. **OSMA**

Michelle J. Carlson is OHIO Medicine’s Editorial Assistant.

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Reproduction Technology: Cataloguing the Criticisms



A Legal View

By Lawrence Grey, JD

Many of the legal publications on birth technology divide the subject into two main categories: preventing birth and facilitating birth. This is a logical arrangement, but I would like to take a different approach, one that I think would be more useful to the physician-reader. In the short space here, I would like to examine some of the issues of birth technology by considering whether they are in the case stage, the consensus stage or the rule stage.

A problem always exists when a person in one profession tries to write for another profession. A physician would have difficulty, for example, writing an article on hypertension for a group of lawyers.

Hypertension in fact is analogous to the point I want to make about the legal aspects of birth technology — *first comes the*

consensus, then comes the rule. In the last 20 or 30 years there has been quite an advance in the treatment of hypertension. Medications for controlling primary hypertension became available and techniques were developed for treating secondary hypertension. Patient awareness has been enhanced dramatically. It would be fair to say that physicians have a handle on this disease. But it was only in 1984 that the Third Joint National Committee on the Detection, Evaluation and Treatment of Hypertension set quantitative standards for what is hypertension. Setting standards is the last stage in the rule-making process.

The legal process mirrors the medical process. First, there are the cases and the results in those cases. From the results, both good and bad, a consensus begins to develop on how these cases should

be handled. The consensus begins to gel into an informal rule of thumb, and eventually this hardens into an almost universally accepted standard or rule. Understanding the legal aspects of any issue of birth technology requires looking at the issue's stage of legal development.

Let's start with artificial insemination and sterilization, two of the oldest birth-related procedures, because in both law and medicine the more familiar we are with something the better we are at handling it. The law is well established that sterilization must be voluntary, and the patient fully advised. The only unresolved legal issue involves the incompetent person where sterilization may be indicated. The question is, who is authorized to give consent? Artificial insemination likewise, is now only a matter of informed consent. In the 1920s there were



“Understanding the legal aspects of any issue of birth technology requires looking at the issue’s stage of legal development.”

cases on whether artificial insemination, without the husband’s consent, constituted adultery. Today it clearly is not adultery, but the husband must consent. In September 1986 the Ohio Legislature passed a comprehensive statute, R.C. 3111.31-38, dealing with donor artificial insemination. The statute deals with consent, medical histories, confidentiality and retention of information about the donor. It specifically does “. . . not deal with the artificial insemination of a wife with the semen of her husband or with surrogate motherhood.” We have a statute on artificial insemination by donors, but don’t have one on in vitro fertilization or surrogate mothering, because the former is very old and the latter quite new.

There still are, of course, cases arising in these areas. In one artificial insemination case, a lesbian using sperm donated by a friend impregnated herself using a household utensil. The donor later sued for visitation rights with the child and prevailed. Sterilization cases usually arise out of the failure of the sterilization, the so-called “wrongful life cases” which we will discuss later.

In vitro fertilization and embryo transfer are, I believe, in the consensus building stage. In vitro fertilization has proven to be an effective and beneficial procedure for many otherwise infertile couples. In spite of some initial outcries against the Huxleyian “test tube babies,” there has been

a general acceptance of in vitro fertilization. Embryo transfer, however, has led to surrogate mothering, and to cases such as the famous Baby M case. At least 20 states have introduced bills to regulate surrogate mothering and 20 more states have introduced legislation prohibiting it. None of this legislation, however, has been passed to date. Recently, a California trial court found surrogate mothering contracts to be void and unenforceable against public policy, i.e. you can’t force the surrogate mother to give up her baby. There are serious legal problems with surrogate mothering, whether done by artificial insemination or by embryo transfer, and I would expect a consensus and rule which strictly limits surrogate mothering, or perhaps bans the procedure entirely. It’s important to remember here that in law, as in medicine, the results in a couple of cases are not much authority. Until there are several well-controlled tests on some procedure done by a recognized medical research institution, there is only medical judgment and opinion. Similarly, until there are several state Supreme Court decisions, and possibly some federal court decisions, the only thing I can give is my judgment and opinion on the way the law is heading.

Genetic screening and genetic counseling are going to present enormous legal problems, as researchers discover more and more markers on the DNA

molecule. Since heart attacks tend to run in families, it’s reasonable to assume that a genetic cause, or at least predisposition, may soon be determined. One writer suggested that employers might require genetic tests for employees to screen out those genetically at risk, and who would therefore increase the employer’s health-care costs. Even more Draconian is deliberately hiring such people because their shorter life expectancy will result in lower total benefits being paid out of the employer’s pension fund. A complete map of the genetic code may lead to these kinds of choices.

In birth technology, where many genetic disorders are already determinable, a physician is obligated to inform and advise patients who may be at risk for genetic disorders such as Tay-Sachs disease for Jewish couples, or Down’s syndrome for older women. For these known genetic disorders, we are at the rule-making stage. A physician must, as always, get a complete medical history and honestly advise at-risk patients. Failure to do so has been held to be malpractice in many cases, and California has a statute requiring physicians to inform patients about the fetal-alpha protein test.

There have also been cases where the treating physician was aware of the potential problem and had tests done, but the test was in error. This has led to the so-called “wrongful birth,” or

“wrongful life” case. Wrongful life is a terrible misnomer, which probably grew out of the tort of negligently causing someone’s death, called a wrongful death action. Wrongful life actions are generally of two kinds — the ones resulting from failed sterilization, and the others resulting from a failure in genetic screening.

In the first kind of case, you usually have a healthy child and the issue is what is the measure of damages. If a sterilization is negligently performed and a child is born, the physician is generally liable for the expenses of the pregnancy and delivery, but generally not liable for the costs of raising the child. There is only one case in Ohio on a failed sterilization, *Bowman v. Davis* (1976), 48 Ohio St. 2d 41. In *Bowman* the Ohio Supreme Court upheld the claim on the grounds of malpractice. The jury awarded \$462,500 in damages, but the issue of the proper amount of damages was not raised on appeal, and so was not decided by the Ohio Supreme Court.

Emotional distress is a significant factor in the second kind of wrongful life cases where a child is born with a genetic disorder. In some states — California, for example — the parents of a Tay-Sachs child may recover damages for emotional distress if the physician failed to discover the condition, thus giving the parents the option to abort. In North Carolina, they cannot recover. In Ohio, this issue has never been decided. I wish I could be more definite, but there are varying results in different states. We are still in the case-deciding mode on this issue, and there appears to be no trend toward a consensus.

One truly vexing problem for

the legal system is what should be the measure of damages for the afflicted child? Is being born with Down’s syndrome better than not being born at all? Is nonexistence ever better than existence? Since a person is only responsible for what he causes, and since the physician does not cause the genetic defect but causes the child *not* to be aborted, should this even be an actionable tort? Again some cases say yes, and some say no, and there is no consensus. There is a trend, though, for courts to say that it is virtually impossible to measure in monetary terms the relative value of “being and nothingness.”

Research into the genome is going to aggravate this problem. As more becomes known about the sources and causes of genetic defects, prenatal tests like amniocentesis and chorionic biopsy are likely to become more common and have fewer complications as problems are discovered and resolved. Since almost all of the wrongful life cases are based on the idea that the parents have been denied the abortion option, prenatal genetic screening will exacerbate the abortion controversy.

On abortion, of course, there is no consensus. The abortion controversy demonstrates most clearly the point I am trying to make about forming a consensus before establishing a rule. Before *Wade v. Roe*, abortions were illegal, but there were many attempts to liberalize abortion laws, and even to legalize it legislatively. Before *Wade v. Roe*, there was no consensus, only a rule against abortion. After *Wade v. Roe*, there is still no consensus, only a rule permitting abortion. The essence of the abortion issue is that the rule has preceded the

consensus, and hence it does not resolve the problem.

The problem is further complicated by the fact that there appears to be a hardening of positions. In all the other areas I have discussed, there appears to be consensus building, or at least a series of non-controversial cases out of which a trend will develop. In abortion, I see no trend toward a consensus, nor even debate on what the consensus should be. I only see a debate over what the rule should be, and that is, of course, futile.

Summary

I must admit that upon re-reading this article, I am not as sure as I was when I began the article that it will be useful and informative to the physician-reader. The law on birth technology, like birth technology itself, is still developing. Physicians can see more clearly than the layman what’s being done and what might be done because they understand the medical process. Physicians, as legal laymen, can best understand the legal process by looking at how the consensus is built.

Can implies ought. In terms of birth technology, the “can” is expanding while society is struggling over the “ought.” Some physicians, like gynecologists and geneticists, are intimately involved in expanding the things we can do; all physicians should become involved in building the consensus, and then the rule, on what we as a society “ought” to do. OSMA

Lawrence Grey, JD, is Judge for the Fourth Appellate District Court, located in Athens, and is a frequent contributor to OHIO Medicine.

Getting Professional Help

By the OSMA Department of Communications and Physician Marketing

Editor's note: *This is the final article in a series on physician marketing, extracted from the OSMA Physician's Marketing Handbook.*

Hiring A Marketing Firm

The previous pages were designed to give you some general "self-help" tips on how to evaluate your current practice, how to pinpoint potential problems and how to improve your relationship with your patients. If your practice is in critical trouble, however, you may want to seek some professional help.

Advertising and marketing agencies have sprung up all across the state; many can help you with a variety of aspects. A good marketing firm, however, will not recommend quick and easy solutions to your problems; rather, it will help you devise both short-range and long-range plans for coping with and improving your particular situation. They can, and most likely will be, both time consuming and expensive.

Generally, there are four steps to a good marketing plan: research, positioning, product and

promotion — a reputable firm will insist that you follow these in order, rather than pushing you into an advertising and promotions program without the proper groundwork. **Research** includes looking at the health-care services around you, as well as your own practice in determining where you fit in and what opportunities you might have. It can be conducted through a variety of means — telephone surveys, mailed questionnaires, one-to-one interviews or focus-group interviews of patients and prospective patients.

Positioning is a process of determining how your practice fits into the total health-care picture — and/or where you would like it to fit in. Your **product** consists of the services you offer people — and how they might be revamped or improved to attract more patients. And, finally, **promotion** is the way you let people know about your product — be it patient information brochures, informal contacts with the media or direct advertising.

Since health care is different from almost any other type of good or service in society — due to its serious, life-and-death implications — it takes a firm with a certain amount of experience and sensitivity to market it effectively. Those inexperienced in this area may recommend action or a promotional activity that is not in keeping with your own philosophy and standards.

On the other hand, however, some experienced, bright and creative marketing professionals may come up with plans and promotions that will both surprise and delight you. The money you spend with them could be one of the best investments that you will ever make in your practice.

The following are some tips on how to select a marketing firm that will suit your needs:

- Before you hire an agency, decide what you would like or need to gain from a marketing program and write it down on paper. Set your own goals, rather

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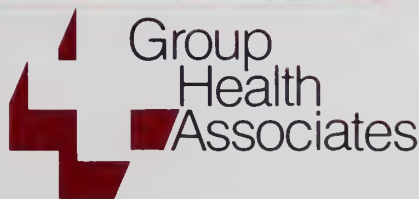
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than having your goals set for you.

- Ask other professionals in your area for the names of marketing firms that have a good reputation in health-care marketing.

- Make a list of questions to ask agencies regarding their background, experience, services and philosophy.

- Interview a number of agencies for the position, comparing rates, services and attitudes toward your particular specialty or situation. (Remember, cheapest isn't necessarily the best deal.)

- Ask agencies for samples of their work — particularly in the health-care field. Also, does the firm have experience working with physicians in your size or specialty of practice, as well as hospitals, clinics and other larger operations?

- Find out who you will be working with directly on the project — the owner of the firm or one of the employees of the agency? What is that particular individual's background, experience and philosophy on the marketing of health care?

- Get a written estimate from each agency on exactly what will be provided — and how much it will cost you. Decide ahead of time just how much you can afford to spend on a program — and ask for bids on what can be provided for that amount.

- Review samples of each firm's work and decide which ones best fit the image and philosophy you would like to present.

OSMA and AMA Marketing Services

Both the Ohio State Medical Association's Department of Communications and Physician Marketing and the American Medical Association's Department

of Practice Management offer a number of services and products that can help physicians with their marketing and communications needs. Some of them are described below. For more information and prices of services, contact the OSMA Department of Communications and Physician Marketing at (614) 228-6971 or call the Department of Practice Management at the AMA at (312) 461-5000.

OSMA Services

Patient Questionnaire — This brochure asks patients to rate your office, your staff and you, giving you some hints as to where your strengths and weaknesses may be. It also provides important information on patient background and demographics, as well as how patients were referred to your practice.

Patient Information Brochure — "Partners in good health" is a patient information brochure which stresses the importance of doctors and patients working together to promote good health. It gives patients general information concerning scheduling, appointments, confidentiality, fees and insurance, along with specific facts about you and your practice. It is custom designed to include your name, background, office hours, hospital affiliations and the services you offer.

Patient Newsletter — The OSMA's quarterly patient newsletter, *Health Hints*, is custom printed with the physician's name, address and office number. This 8½" x 11", two-color publication contains seasonal information on a variety of health topics and is ideal for distributing to patients in your office or by mail.

Media Training Seminars — The Department of Communications and Physician Marketing sponsors media training seminars for

physicians who want to develop skills in presenting their ideas to the news media. Seminars include on-camera interviews and personal critiques, along with a variety of tips on how to answer the questions of news reporters effectively. (Sponsored by special arrangement through your county medical society and specialty society.)

AMA Services

AMA Practice Development Publications Audio Visuals —

Patient Relations Pack. Improve patient relations skills with the three items in this package: "Winning Ways with Patients," "Preparing a Patient Information Booklet," and "Talking with Patients."

Patient Survey Questionnaire. A device for the physician, measuring the satisfaction of patients regarding different aspects of the practice, from patients' reasons for selecting the doctor, to office appearance.

The Business Side of Medical Practice. A guide to basic management principles for the medical office. Topics include setting up a practice, selecting a location, financing, clearing legal hurdles, insurance, hiring and supervising personnel, appointment scheduling, medical records, billing and collecting, and patient relations.

Medical Collection Management. This intensive course focuses on incorporating efficient collection practices into everyday office procedures. Cassette and workbook.

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Proposed Changes to OSMA Constitution and Bylaws

Introduced by: OSMA Council
Subject: Requiring a Completed Ballot

RESOLVED, That the Bylaws of the Ohio State Medical Association be amended as follows:

Chapter 5: Nomination and Election of Officers

Section 7: Election of Officers and Delegates and Alternate Delegates of the American Medical Association

Paragraph 3: Add the following at the end of the paragraph: NO BALLOT SHALL BE COUNTED IF IT CONTAINS FEWER OR MORE VOTES THAN THE NUMBER OF POSITIONS TO BE FILLED OR IF THE BALLOT PURPORTS TO CAST

MORE THAN ONE VOTE FOR ANY NOMINEE. (FOR EXAMPLE: IF UPON ANY BALLOT THE NUMBER OF POSITIONS TO BE FILLED IS FOUR (4), THEN EACH DELEGATE VOTING MUST VOTE FOR (4) OF THE NOMINEES FOR SUCH POSITIONS.)

Subject: Publication Charge to Retired and Disabled Exempt Members

WHEREAS, postal regulations require that the number of complimentary copies of an Association's publications be limited; and,

WHEREAS, failure to control mailing of complimentary publications would cause the OSMA to lose their reduced rate postal permit; and,

WHEREAS, this loss of postal permit would considerably raise the postal rate of mailing publications to all members,
THEREFORE BE IT

RESOLVED, that the OSMA charge a publication fee of \$40 to retired and disabled exempt members effective in 1988, and,
BE IT FURTHER

RESOLVED, that the exempt member retain his membership if the physician chooses not to

receive the publications by paying the \$40 charge.

Subject: Reduction of Dues for Physicians in their Second Year of Practice

WHEREAS, thorough research was conducted by the American Medical Association resulting in its adoption of reduced dues for physicians in their second year of practice; and

WHEREAS, OSMA now offers a dues reduction for the first year in practice; and

WHEREAS, state medical societies are encouraged to take advantage of the opportunity that for continued dues reduction in the second year of practice offers for membership development both at the state and county levels; and,

WHEREAS, the adoption of a standard unified membership dues structure is advisable;
THEREFORE BE IT,

RESOLVED, That the OSMA dues for Active Members and Associate Members be reduced by 33⅓% for physicians in their second year of practice after training is completed.

Editor's Note:

The following resolutions have been submitted for consideration at the 1988 OSMA Annual Meeting. Since these resolutions propose to change the OSMA Constitution and Bylaws, they must be published in the OSMA Journal 60 days before the meeting, as is required by Article II of the Constitution and Chapter 15 of the Bylaws.

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Subject: Dues Increase Resolution

WHEREAS, even though the OSMA has exhaustively sought non-dues revenue to supplement the dues and keep the members' dues rate at the lowest level, non-dues revenue has dropped from 30% in 1984 to 23% in 1987 and,

WHEREAS, Ohio is considered among the top state medical associations in the country with vigorous programs to meet members' needs, but ranks eight among the top 10 state medical societies in the current dues-rate assessed to its members; and,

WHEREAS, the OSMA will be using its reserves to fund a deficit budget in 1988, and it must continue to meet the onslaught of challenges brought about by changing attitudes of the public and government concerning the provision of medical care; and,

WHEREAS, representation of the members continues to increase at the legislature, with state and federal rule-setting bodies, the state medical board, the media, the public, the membership and with third-party payers; and,

WHEREAS, the OSMA must be ready to respond on behalf of its members to health care issues such as DRG's, alternative health care delivery systems, changes in hospital medical staff and competition; and,

WHEREAS, the OSMA can only maintain its position as the spokesman for the physicians of Ohio under the umbrella which unites all specialties of practice, residents, and students of medicine with adequate financial resources,
THEREFORE, BE IT

RESOLVED, That the dues of the Ohio State Medical Association be increased from \$295 in 1988 by \$60 for 1989 and by an additional \$30 in 1990, and an additional \$30 in 1991.

Subject: Resolutions by Hospital Medical Staff

WHEREAS, the Hospital Medical Staff Section was organized at both the state and national level to provide a method for representatives from hospital medical staffs to bring pertinent issues quickly to the attention of organized medicine; and

WHEREAS, the Ohio State Medical Association has encouraged the growth and development of the OSMA-Hospital Medical Staff Section; and

WHEREAS, the Ohio State Medical Association-Hospital Medical Staff Section desires a method to introduce a limited number of pertinent resolutions to the OSMA House of Delegates for their immediate consideration; and,

WHEREAS, Section 11 of the OSMA Bylaws currently preclude the introduction of resolutions from the Hospital Medical Staff Section, due to time constraints; Therefore, be it

RESOLVED, That the Bylaws of the Ohio State Medical Association be amended as follows:

Section 11. Resolutions.
EXCEPT AS OTHERWISE PROVIDED UNDER SECTION 12, every resolution to be presented to the House of Delegates for action, shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. Each resolution which, if adopted, would require expenditure of

funds by the Association, shall have attached, a statement of the amount of the estimated annual expenditure. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived **UNDER SECTION 12, OR** by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates.

The Executive Director shall cause to be published in the *Journal* in advance of such meeting of the House of Delegates such resolutions as the President or the Council may designate.

No consideration may be given, or any action taken, by the Committee on Resolutions or by the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates; provided, however, that a resolution dealing with an event or development occurring too late to permit the introduction of any such resolution at the opening session

may be introduced at a later session with the consent of at least four-fifths (4/5) of the delegates present; and upon its introduction, such resolution shall be referred to the Committee on Resolutions for consideration and report; and, provided further, that the Committee on Resolutions shall have the right to amend any resolution presented or introduced, or to draft a composite or substitute resolution embracing the same subject matter as that contained in a resolution or resolutions presented or introduced, and to submit such amended, composite or substitute resolution for adoption by the House of Delegates, and the House of Delegates shall have the right to adopt any such amended, composite or substitute resolution.

Any resolution adopted by the House of Delegates in 1979 and thereafter will become null, void and of no effect if not repropounded and readopted within four years from the effective date of the adoption of the resolution. Within the fourth year of their effective date, the House of Delegates will be notified by January 31 in writing of those resolutions subject to readoption at the Annual Meeting at which they will be considered.

SECTION 12 — Hospital Medical Staff Section Resolutions — A MAXIMUM OF FIVE RESOLUTIONS, DIRECTLY RELATED TO ISSUES OF CONCERN TO PHYSICIANS ON HOSPITAL MEDICAL STAFFS AND MATTERS OF IMMEDIATE IMPORTANCE, ADOPTED BY AND PRESENTED FROM THE BUSINESS MEETING OF THE HOSPITAL MEDICAL STAFF SECTION REPRESENTATIVE ASSEMBLY, AS PROVIDED IN

THEIR BYLAWS, MAY BE PRESENTED FOR CONSIDERATION BY THE HOUSE OF DELEGATES AT ANY TIME BEFORE THE OPENING OF THE HOUSE OF DELEGATES. ALL OTHER RESOLUTIONS ADOPTED BY AND PRESENTED FROM THE BUSINESS MEETING OF THE REPRESENTATIVE ASSEMBLY OF THE HOSPITAL MEDICAL STAFF SECTION SHALL BE SUBMITTED IN REPORT FORM TO THE HOUSE OF DELEGATES AT THE FOLLOWING YEAR'S ANNUAL MEETING OF THE HOUSE OF DELEGATES FOR PURPOSE OF FILING.

All other sections of the Bylaws should be renumbered accordingly.

**Subject: Spouse Active Membership
Sponsored by the Academy of Medicine of Columbus and Franklin County**

WHEREAS, an increasing number of couples in which both spouses are physicians are entering medical practice; and

WHEREAS, it is estimated in Ohio alone there are 300-400 physician couples; and

WHEREAS, with many physician couples, only one spouse is an active member of organized medicine; therefore be it

RESOLVED, That the OSMA Council, in an effort to recruit more physician/physician couples, each with separate membership, recommends that a new category of membership be created to allow for dual membership by spouses with a reduced dues structure for the couple; and, be it further

RESOLVED, That the Constitution and Bylaws of the OSMA be amended as follows:

CONSTITUTION

ARTICLE III — Section I

1. Active Members/SPOUSE ACTIVE MEMBERS (including retired active members)

BYLAWS

Chapter 1.

Section 2. Classification of Membership

(a) Active members/SPOUSE ACTIVE MEMBERS. Active members of this Association shall comprise all the active members AND SPOUSE ACTIVE MEMBERS in good standing of the several component societies. Active members AND SPOUSE ACTIVE MEMBERS shall have the right to vote and hold office.

Section 1. Determination of Dues. The annual dues and assessments of Active Members and Associate Members of this Association shall be determined by the House of Delegates and shall be levied per capita on such members. **A MEMBER WHO IS THE SPOUSE OF AN ACTIVE MEMBER IS ELIGIBLE FOR A REDUCTION FROM THE PER CAPITA DUES AND ASSESSMENTS DETERMINED BY THE HOUSE OF DELEGATES. THE COUNCIL OF THIS ASSOCIATION SHALL HAVE THE AUTHORITY TO PROMULGATE THE AMOUNT OF DUES AND ASSESSMENTS FOR AN ACTIVE MEMBER'S SPOUSE.** They shall be payable before January 1 of the calendar year for which such dues are levied. The dues and assessments shall be collected by the designated officer of each component society and shall be forwarded to the headquarters of this Association, together with such data as shall be

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OHIO Medicine

Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, OHIO Medicine, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be **DOUBLE SPACED** with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) should bear the figure number and author's name on back. When pertinent, the top of the photograph should be indicated. Do not clip or write on the back of the photos with a hard pencil, etc.

(b). The author should have written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

11. **CASE HISTORIES.** The *Journal* does not accept case histories.

12. **EDITORIAL ASSISTANCE.** Michelle Carlson, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

OBITUARIES

C.H. BELL, MD, Mansfield; Ohio State University College of Medicine, 1926; age 87; died October 13, 1987; member OSMA and AMA.

HAROLD CARTER, MD, Columbus; Ohio State University College of Medicine, 1944; age 70; died December 8, 1987; member OSMA and AMA.

FRANCIS CURTZWILER, MD, Toledo; St. Louis University School of Medicine, St. Louis, MO, 1931; age 81; died November 12, 1987; member OSMA and AMA.

GILBERT H. DERIAN, MD, Middleburg Hts.; Medical School, University of Beirut, Beirut, Lebanon, 1946; age 65; died November 25, 1987; member OSMA and AMA.

CHARLOTTE DELHAES, MD, Walton Hill; Medizinische Fakultät der Georg-August-Universität, Göttingen, Niedersachsen, Germany, 1949; age 73; died November 21, 1987; member OSMA.

MARVIN GOLDSTEIN, MD, Youngstown; University of Pennsylvania School of Medicine, Philadelphia, PA, 1924; age 87; died November 2, 1987; member OSMA and AMA.

CHARLES C. HIGGINS, MD, Painesville; Washington University School of Medicine, St. Louis, MO, 1923; age 90; died November 10, 1987; member OSMA and AMA.

JEROLD K. HOERNER, MD, Sanibel Island, FL; Johns Hopkins University School of Medicine, Baltimore, MD, 1923; age 89; died December 6, 1987; member OSMA and AMA.

J. ROBERT HUDSON, MD, New Orleans, LA; Eclectic Medical College, Cincinnati, 1937; age 77; died November 1, 1987; member OSMA and AMA.

WILLIAM KROOVAND, MD, Cincinnati; University of Louisville School of

Medicine, Louisville, KY, 1939; age 72; died November 29, 1987; member OSMA and AMA.

GEORGE LESAR, MD, Marco Island, FL; Case Western Reserve University School of Medicine, 1941; age 70; died November 24, 1987; member OSMA and AMA.

J. STEWART MATHEWS, MD, Stuart, FL; University of Cincinnati College of Medicine, 1923; age 89; died November 14, 1987; member OSMA and AMA.

ARMANDO C. MIRANDA, MD, Cleveland; Faculty of Medicine & Surgery, University of Santo Tomas, Manila, Philippines, 1962; age 49; died November 21, 1987; member OSMA and AMA.

JOSEPH A. PRESTON, MD, Cincinnati; New York Medical College, New York, NY, 1951; age 61; died November 30, 1987; member OSMA.

LUTHER ROBINSON, JR., MD, Akron; Howard University College of Medicine, Washington, DC, 1961; age 51; died November 29, 1987; member OSMA.

HANS SEIDEMANN, MD, Cleveland; Schlesische-Friedrich-Wilhelm Universität Medizinische Fakultät, Breslau, Germany, 1925; age 85; died November 15, 1987; member OSMA and AMA.

JOSEPH J. WASILKO, MD, Youngstown; Case Western Reserve University School of Medicine, 1934; age 81; died November 25, 1987; member OSMA and AMA.

LEE V. WEIS, MD, Sidney, OH; Ohio State University College of Medicine, 1929; age 84; died November 26, 1987; member OSMA and AMA.

ANDREW E. WEISS, MD, Peoria, IL; University of Cincinnati College of Medicine, 1967; age 48; died November 12, 1987; member OSMA.

required by this Association for its own record of such society's officers and membership.

Fiscal Note: None submitted.

Title: Hospital Medical Staff Section Councilor
Submitted By: OSMA-HMSS Governing Council

WHEREAS, the Hospital Medical Staff Section was organized at both the state and national level to provide a method for representatives from hospital medical staffs and leaders of organized medicine into closer communication; and

WHEREAS, the Ohio State Medical Association has encouraged the growth and development of the OSMA-Hospital Medical Staff Section; and

WHEREAS, the Ohio State Medical Association-Hospital Medical Staff Section desires to develop a continuity of communication between the elected representatives of the OSMA and the elected representatives of the Hospital Medical Staff Section; and,

WHEREAS, OSMA Constitution and Bylaws currently provide for representation on the Council for all other sections of the Association; Therefore, be it

RESOLVED, That the Constitution and Bylaws of the Ohio State Medical Association be amended as follows:

Constitution of The Ohio State Medical Association

**ARTICLE VII
THE COUNCIL**

The Council shall consist of one councilor from each councilor district, ONE NON-VOTING MEMBER FROM THE HOSPITAL MEDICAL STAFF

SECTION, one non-voting councilor from the Resident Physician's Section, one non-voting student member from the Medical Student Section and the other elected officers of this Association. The Council shall be the executive body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates.

**BYLAWS OF THE OHIO STATE MEDICAL ASSOCIATION
CHAPTER 7 — SECTION 4**

Section 4. Individual Duties of Councilors. Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in his district and of keeping in touch with the activities of each of such societies. In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics. THE DUTIES OF THE NON-VOTING COUNCILOR FROM THE HOSPITAL MEDICAL STAFF SECTION SHALL BE SET FORTH IN THE BYLAWS OF SAID SECTION. The duties of the non-voting Councilor from the Medical Student Section shall be set forth in the Bylaws of said section. The duties of the Councilor from the Resident Physician's Section shall be set

forth in the Bylaws of said section which shall be approved by the Council.

President's Page . . . continued

1. Financial difficulties. Participants in the interviews reported increased difficulties in receiving payment for their services from third-party payers. Many feel these delays are intentional on the part of the payers, both private and public. The participants also were very disturbed with the fees established by third-party payers.
2. Standardization of forms. The absence of a standardized claim form was a universal complaint among all participants. Physicians resent the expense and staff time required to process a variety of claim forms which essentially seek the same information.
3. Unification of codes. As with standardization of forms, physicians resent the fact that they and their staffs must spend countless hours updating themselves in the use of different codes for similar procedures. Failure to do this results in billing errors and delays in payment.
4. Contract review and comparison. Participants expressed frustration over the fact that they feel they are financially forced into participating in practically every contract offered, but they have no way of judging the benefits of participation.
5. Upgrade third-party payer staff. Since the terms and conditions of many third-party programs are difficult for physicians and staff to understand, they must,

continued on page 221

Proceedings of the Council

November 14, 1987

PROCEEDINGS OF THE COUNCIL

**HYATT ON CAPITOL
SQUARE, COLUMBUS
NOVEMBER 14, 1987**

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, November 14, 1987 at the Hyatt on Capitol Square in Columbus, Ohio.

Those present were:

D. Ross Irons, MD, President
Donavin A. Baumgartner, Jr., MD, Cleveland
Joseph Sudimack, Jr., MD, Columbus
Stanley J. Lucas, MD, Cincinnati
William J. Marshall, MD, Dayton
Thomas R. Leech, MD, Lima
John A. Devany, MD, Toledo
Henry G. Krueger, MD, North Olmstead
J. James Anderson, MD, Youngstown
Nermin D. Lavapies, MD, Martins Ferry
John F. Kroner, Jr, MD, Athens
Thomas P. Price, Jr., MD, Gallipolis
H. William Porterfield, MD, Columbus
Charles G. Adams, MD, Vermilion
Jack L. Summers, MD, Akron

Derrick Jeter, Dayton, President
Medical Student Section
Frederick Bronn Rayne, MD, Columbus, Resident Physician Section
Oscar W. Clarke, MD, Gallipolis, Chairman AMA Delegation
Joyce Johnson, President OSMA Auxiliary
Ronald L. Fletcher, MD, Director Ohio Department of Health
Ray W. Gifford, Jr., MD, Cleveland, AMA Board of Trustees
Bob Dion, Columbus, PICO
Mark Hannan, Columbus, PICO
Victoria Ruff, MD, Columbus, Young Physicians Section
Herman Abromowitz, MD, Chairman Committee on Judicial & Professional Relations
Those present from OSMA staff:

Herbert E. Gillen
D. Brent Mulgrew, Esq.
Jerry J. Campbell
Robert D. Clinger
Katherine E. Wisse
Gail E. Dodson
David C. Torrens
Carol W. Mullinax
Deborah Bahnsen, Esq.
William E. Fry
Carolyn H. Towner
Kent Studebaker
Doug Graff, Esq.
John Van Doorn

Rick Ayish
David W. Pennington
Vickey McVay
Margaret High-Thomas
Jim Wile
Karen Edwards

President's Report

Dr. Irons reported on his travels and activities on behalf of the Association since the last Council meeting. Included in his report was an update on the current status of PICO situation as regards to the Ohio Department of Insurance.

Previous Minutes

Minutes of the September 12, 1987 meeting of the Council were approved as distributed.

Executive Director's Report

Mr. Gillen reported that Cathy Costello had provided him with a letter of resignation. Dates for the AMA Leadership Conference in Chicago were announced for February 12-14, 1988. Mr. Gillen reported on meetings staff has had with County Society executives in order to improve relationships and activities. Council was asked to give consideration to selecting a physician for the Distinguished Physician Award for presentation at the OSMA Annual Meeting.

Legislative Report

Dr. Herman Abromowitz, Chairman of the Committee on Legislation reported on the joint

meeting of the committee with the OMPAC Board held on October 28, 1987. Mr. Ayish presented the action items from the October 28 meeting. The Council approved the recommended actions of the committee as follows:

- 1) The OSMA Aids Task Force recommended that the OSMA Legislative Committee have the Legislative staff arrange a dinner meeting for the OSMA Aids Task Force with the Ohio Senate and Ohio House of Representatives Health Committees for the purpose of educating the health committee legislators on AIDS.

ACTION: Unanimously Approved

- 2) **SENATE BILL 258** (Ney, R-Barnesville) — **Notification to Funeral Directors.** This bill would require the attending physician or coroner who signs a medical certificate of death of a deceased person who had the presence of a contagious or infectious disease to notify the funeral director of the disease prior to the receipt of the body.

ACTION: Oppose with Technical Assistance

- 3) **HOUSE BILL 538** (Gilmore, R-Columbus) — **Blood Tests for Food Handler's Permit.** This bill would require an employee of a food service operation to obtain a food handler's permit and to take a blood test to determine whether the applicant for the permit has a contagious or infectious disease.

ACTION: Strongly Oppose

- 4) **HOUSE BILL 551** (Gilmore, R-Columbus) — **Human Immunodeficiency Virus Antibodies.** This bill would require a coroner or deputy coroner to perform one or more laboratory tests of HIV antibodies on each body that the coroner or deputy coroner takes charge of and to notify any relative or friend of the

deceased who may be at risk if the body tests positive.

ACTION: Oppose with Technical Assistance

- 5) **HOUSE BILL 571** (Adams, R-Marion) — **Blood Donations or Sales.** This bill would prohibit any person, with knowledge that he is an AIDS carrier, from selling or donating blood.

ACTION: Strongly Support with Technical Assistance

- 6) **HOUSE BILL 627** (Byers, R-Loudenville) — **HIV Testing.** This bill would require testing for the human immunodeficiency virus for marriage license applicants, health-care professionals licensed or certified in Ohio, persons employed by health-care professionals, persons employed by a health-care facility, persons whose work required providing direct care to patients or residents of a health-care facility, food service operation employees, and persons sentenced to a penal institution.

ACTION: Strongly Oppose

Mr. Ayish discussed a proposed amendment to the physical therapy statutes. The following amendment to Section 4755.50 of the Revised Code was accepted by the Council as a policy statement and referred to the committee on Legislation for further consideration and refinement:

"Sec. 4755.50. Nothing in this chapter shall be construed to prevent or restrict the practice of any person who is a licensed practitioner of HEALTH-CARE PROFESSIONAL in the state of Ohio, WHILE PRACTICING WITHIN THE SCOPE OF HIS LICENSE AND ACCORDING TO THE STANDARDS AND ETHICS OF HIS PROFESSION, or of anyone employed or supervised by ACTING UNDER THE DIRECT

SUPERVISION OF such LICENSED HEALTH-CARE PROFESSIONAL person. HOWEVER, SERVICES RENDERED BY SUCH PERSON SHALL NOT BE DESIGNATED AS PHYSICAL THERAPY, EXCEPT SERVICES PERSONALLY RENDERED BY A PHYSICIAN LICENSED UNDER CHAPTER 4731 OF THE REVISED CODE TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY."

Mr. Ayish pointed out that this amendment would prohibit licensed health-care professionals, except licensed MD's and DO's, from designating services as physical therapy.

Mr. Van Doorn discussed current legislation activities with emphasis on the breast cancer bill and the mandatory assignment bill.

Mr. Ayish discussed the H.B. 494 HMO study committee and its activities.

OMPAC

Mr. Ayish discussed the organization of the Ohio Medical Political Action Committee. The Council approved the following nominations to the OMPAC Board:

Joseph Fisher, MD, Cincinnati,
District One
Su-pa Kang, MD, Toledo,
District Four

AMA Activities

Dr. Ray Gifford, AMA Trustee, discussed the need to bring order (on a scientific basis) to the entire AIDS situation. He also discussed the need for unity of the profession in dealing with the reimbursement issues under Medicare. The AMA membership incentive plan was discussed.

Dr. Oscar Clarke reported on the meeting of the Planning and

Strategy Committee of the AMA Delegation held on September 13, 1987. On recommendation of the Committee, the Council approved the following candidates for AMA offices and awards:

John E. Albers, MD, Council on Medical Education
H. William Porterfield, MD, Council on Medical Services
Richard M. Steinhilber, MD, Council on Scientific Affairs
Hart F. Page, Distinguished Service Award
Leslie B. Huffman, MD, Council on Long Range Planning

Dr. Clarke discussed the possibility of getting appointed to the AMA Council on Ethical and Judicial Affairs by AMA President Hotchkiss. The Council voted to support Dr. Clarke's nomination to this Council.

Dr. Victoria Ruff reported on the activities of the Young Physician Section and indicated a willingness to be available to local medical societies to speak on issues facing young physicians. *Ohio Director of Health Report*

Dr. Ronald Fletcher addressed the Council on several health issues. He indicated he would be requesting nominations from the Association to serve on the Severity of Illness Advisory Committee and the Hospital Quality of Care Indicators Advisory Group called for in H.B. 86 — Hospital Data Bill. Dr. Fletcher also discussed the AIDS situation in Ohio, as well as a developing problem in the delivery system for obstetrics in Ohio. *PICO Report*

Mr. Mark Hannan and Robert Dion of PICO management addressed the Council and answered questions about professional liability insurance. *OSMA Auxiliary Report*

Mrs. Joyce Johnson reported on the successful Ohio Fall Auxiliary Confluence and reported the

Auxiliary Day at the Legislature would be March 9, 1988. Mrs. Johnson presented an Auxiliary resolution entitled "Preschool Smoking Prevention Education" which subsequently was endorsed by the Council.

Committee Reports for Action

Dr. Marshall presented the minutes of the October 28, 1987 meeting of the Committee on Auditing and Appropriations. On recommendation of the Committee the Council approved the 1988 revenue budget of \$4,513,882 and an expense budget of \$4,634,262.

The Treasurer's report was approved as distributed.

Dr. S. Marcus Wigser, Chairman, presented the minutes of the July 10, 1987 meeting of the Committee on Judicial and Professional Relations. On recommendation of the Committee, the Council approved the following statements for guidance for patients and physicians involved with second surgical opinion programs:

- 1) The JPR Committee recognizes that OSMA House of Delegates policy opposes mandatory second opinion programs.
- 2) Second opinions, when appropriate, are valuable to the patient and to the physician.
- 3) A patient has an unqualified right to a second opinion if he or she requests one.
- 4) When time permits in non-emergency situations, the third-party payor should furnish the second opinion physician with a statement from the first opinion physician specifying the basis for the first opinion.
- 5) Second opinions should be furnished by physicians who have experience with a patient's particular disease or problem (please see AMA Resolution 28; I-86). However, second opinion physicians need not be of the same specialty as the first opinion physician.

6) The patients should always have the ability to request care from whichever physician he or she chooses.

7) If a second opinion is mandated by a third-party payor and the patient wishes to transfer his care to the second opinion physician, the patient should be required to inform the first opinion physician and the third-party payor of his decision. The committee recommends that third-party payors prohibit, by contract, the second opinion physician from taking on the continuing care of the patient, unless the patient specifically requests the transfer. The committee also recommends that, where a second opinion is mandated, the second opinion physician should direct the patient to return to the first opinion physician for a discussion of the second opinion. This discussion should occur at the third-party payor's expense.

8) Unless the patient prohibits the communication, physicians offering second opinions in a voluntary situation should inform the patient that they wish to discuss the second opinion and analysis with the first opinion physician.

On recommendation of the Committee, the Council approved the following statement regarding physician dispensing of drugs:

"The Ohio law and AMA ethical guidelines do not prohibit physicians from dispensing drugs. Nationally, the number of physicians who dispense drugs has not been large. However, the number is increasing. Physicians are cautioned that the type of arrangement under which the drugs are sold may make the dispensing illegal. For example, if the physician

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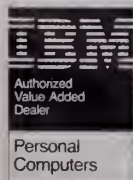
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enters into an agreement to share a percentage of the sale price markup with another person, such as the supplier or pharmacist, the prohibition in Ohio law against fee splitting could make this type of arrangement illegal.

The Judicial and Professional Relations Committee has reviewed ethical issues surrounding physician office dispensing. The J&PR Committee has determined that physician office dispensing is not a violation of the ethical guidelines of the medical profession. However, physicians should not dispense non-labeled, inadequately labeled, or personally manufactured drugs. Any drug or device dispensed by a physician should not be more expensive than the same product at retail, or should be less expensive.

The Committee believed that the Ohio State Medical Association should vigorously pursue any complaints in this area to ensure that ethical guidelines against patient exploitation and fee splitting are strictly enforced."

The Committee recommended and the Council approved that the Committee on Judicial and Professional Relations be designated as the "Statewide Ethics Committee" as referred to in OSMA Resolution 51-87.

Mr. Clinger presented the minutes of the September 20, 1987 meeting of the Committee on Impaired Physicians. On recommendation of the Committee, the Council approved the following action:

"That the OSMA express to Ohio Medical School deans in writing its concerns relative to the apparent lack of reasonably-priced health

insurance coverage for medical students — especially in areas of chemical dependency, mental and emotional health."

Mr. Clinger presented the minutes of the September 30, 1987 meeting of the OSMA-ONA-OOA Liaison Committee. On recommendation of the Liaison Committee, the Council approved the following joint statement on "First Assistant In Surgery":

"The OSMA-ONA-OOA Liaison Committee believes that first assisting in surgery should be performed by a qualified physician. If any hospital requires a nurse, as a term of employment, to serve as first assistant in place of a physician, such hospital must provide appropriate training and place the requirement in the nurse's job description. In cases where a nurse is assigned as a first assistant, the assigned nurse should not also function as the scrub or instrument nurse."

Mr. Clinger presented the minutes of the September 25, 1987 meeting of the Committee on Cancer. On recommendation of the Committee, the Council approved the following policy statements:

1. That cancer screening centers throughout Ohio — with or without apparent physician supervision — be identified by members of the Committee. A letter seeking this information will be prepared by staff and sent to all members.
2. That a subcommittee consisting of Drs. Cobau, Stanislaw, Minton and Sholtis invite representatives of the centers identified in 1) to meet with the subcommittee in late 1987 to discuss the concerns raised by the Task Force on Cancer Screening, as well as the

continued on next page

with increasing frequency, turn to the program administrators for assistance. The problem is that these administrators are often less than helpful. They are trained to say "no." There is no opportunity to talk with the same individual twice when asking for assistance. They are not medically trained, yet they are making medical decisions. This process is frustrating and is forcing physicians to practice what they believe to be unethical medicine.

6. Standardize coverage. This difficulty is again contract-related. Since the terms of coverage, the methods of administration and the numbers of covered patients are constantly changing, the situation has become extremely confusing for the physician. When these problems are multiplied by 12 to 30 plans in which a physician may participate, the problems are magnified beyond any acceptable degree.
7. Education of patient/user. Managed care is confusing for patients as well as physicians. Patients tend to believe that their programs are all-inclusive. Furthermore, they are not told by employers that the plan was adopted to control health-care costs. As a result it is often the physician who must explain that a treatment is not covered, and the relationship between the patient and physician becomes strained.
8. Restoration of physician's authority. Managed health-care programs have made the physician a secondary partner in health care. Participants felt they worked for insurance companies, not themselves and that this was having a detrimental effect on patients as well as the profession.

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- recommended guidelines included in the report.
3. That a subcommittee consisting of Drs. William and Myers study the report and recommendations of the Task Force on Cancer Screening — and prepare a draft of a “checklist” for physicians’ offices.
 4. That county-by-county listings of physicians willing to take referrals from the Ohio Cancer Information Service be updated.
 5. That OSMA reaffirm the position of active opposition to House Bill 215. Good medicine cannot be legislated. To legislate for one disease makes even less sense. Every physician treating breast cancer should discuss alternatives of treatment with the patient.
 6. That every physician should have copies of the American College of Surgeons’ pamphlet prepared in cooperation with OSMA entitled, “Breast Cancer: Diagnosis and Treatment Information.”
 7. That physicians serving on the Committee on Cancer volunteer their services to provide testimony, when requested, before the Ohio General Assembly on legislative measures involving cancer.”

Mr. Campbell presented the minutes of the September 26, 1987 meeting of the Ad Hoc Committee to Review House of Delegates Voting Procedures. On recommendation of the Committee, the Council took the following actions:

1. That Chapter 5, Section 7 of the OSMA Bylaws be amended as follows: “No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one vote for any nominee.” (For example: If upon any ballot the number of

- positions to be filled is four (4), then each delegate voting must vote for four (4) of the nominees for such positions.)
 2. That the Bylaws change be processed so that, if adopted, it becomes effective for candidate selection purposes at the 1988 OSMA Annual Meeting.
 3. That the electronic ballot tabulation system using the Scan-Tron machinery and paper ballots be approved by Council for use at the 1988 OSMA House of Delegates meeting.
- Mr. Campbell presented the minutes of the October 14, 1987 meeting of the Ad Hoc Committee to Review OSMA House of Delegates Policy. On recommendation of the Committee the Council took the following actions:

1. That the Ad Hoc Committee to Review OSMA House of Delegates Policy be designated an operational committee and named the Committee to Review OSMA House of Delegates Policy.
2. That the following resolutions adopted by the 1984 OSMA House of Delegates *be retained*:
Special Session,
April 14, 1984 PRO
- 3-84 Dues Increase
- 8-84 Hospice Care Regulations
- 9-84 Medical Care for the Elderly
- 10-84 DRGs
- 13-84 Third Party Reimbursement Problems
- 16-84 Cognitive Services Reimbursement
- 21-84 Payment for Physician’s Services
- 26-84 CPT-4 Codes for Complex Services
- 32-84 Report on Resolutions From Prior Years
- 36-84 Physician Criticism of Colleagues
- 37-84 Hospital Ethics Committee
- 38-84 Free Choice of Physician
- 43-84 Financial Support —

- Homeless and Chronically Mentally Ill
- 46-84 Mandatory Use of Protective Helmets for Motorcyclists
 - 49-84 Preference for Hospital Delivery Over Home Births
 - 50-84 Supervision of Physician Assistants
 - 55-84 ACLS and ATLS Courses for Physicians
3. That the following resolutions adopted in 1984 *not be retained*:
- 1-84 Revised Voting Procedure
 - 5-84 Establishment of Hospital Medical Staff Section
 - 6-84 Medicaid Reimbursement Revision
 - 12-84 Assignment of Benefits
 - 19-84 The Proper Role for the OSMA in Member Negotiations
 - 23-84 Military Physician Members
 - 29-84 Patient and Public Information Program
 - 33-84 Life-Sustaining Therapy
 - 34-84 Physician Liability Exposure in Participation Agreements
 - 42-84 Resident Section — OSMA
 - 44-84 User Tax on Cigarettes
 - 45-84 User Tax on Alcohol
 - 47-84 The Use of Seat Restraints for Automobiles in the State of Ohio
 - 48-84 Recognition of the 150th Anniversary of the Ohio State College of Medicine
 - 51-84 Funding for the Ohio State Medical Board
 - 53-84 Appreciation of OSMA Support
 - 54-84 Cooperative Coalition of Committee
 - 56-84 Inappropriate Sale of Fireworks
 - 57-84 Violence in Movies and TV
 - 58-84 Public Purchase and Consumption of Alcoholic Beverages
 - 59-84 Recognition of Valor — Medical Rescue Team
 - 61-84 Enhanced 911 Telephone System

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|--|---|--|
| 62-84 Lake Erie Valor
Commendation
Report
A Report of the Ad Hoc
Committee to Review
OSMA House Delegates
Policy (1980 policy) | 21-78 Accountability
24-78 Collateral Source
25-78 Tort Reform
28-78 Amendments to H.B. 682
45-78 Community Mental Health
Centers
58-78 Ohio Department of Public
Welfare
5-79 Insurance Coverage for
Ambulatory Surgery
44-79 National Health Planning
and Resources Development
Act of 1974
47-79 Use of Social Security
Numbers as Universal
Identifiers
7-80 Mandatory Continuing
Medical Education
49-80 Regionalization of Medical
Services
12-81 Ohio State Medical
Association Annual Meeting
15-81 Women in Medicine | 23-81 Reconvene Task Force on
Professional Liability
47-81 Manpower
50-81 "PAP Smear" Law
60-81 Hospital Malpractice
10-82 Establishment of a Resident
Physician's Committee
Within the OSMA
13-82 Mandatory CME
23-82 Health Planning Advisory
Panels
31-82 Strengthening of Ohio's
Drunk Driving Laws
17-83 Control of Look-Alike
Drugs and Over-the-
Counter Drug Abuse
20-83 Handicapped Children
21-83 Problems of the Senior
Citizens
30-83 Contraceptive Devices for
Minors |
|--|---|--|
4. That the following resolutions
adopted from 1929-1983 *not be
retained:*
- 1959 Universal Immunizations
20-69 Reimbursement as it Relates
to Health Planning
Agencies
44-72 Regional Medical Programs
2-75 Professional Liability
Commission
1-76 Parliamentary
30-77 Liability Reform
75-77 Recommended Alterations
of Hospital Discharge
Summaries
19-78 MSMS vs. BC/BS

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Council Proceedings . . . continued

Mrs. Dodson presented the minutes of the November 6, 1987 meeting of the Committee on Education. On recommendation of the Committee, the Council approved the format of the 1988 Annual Meeting with the exception that the OMPAC luncheon will be on Saturday. The exhibit space rental fee for the 1988 Clinical Update meeting was set at \$650.

Committee Reports for Filing

The Council received the following committee reports for filing:

1. Subcommittee on Legislation, Policies & Guidelines, Joint Advisory Committee on Sports Medicine, Sept. 2, 1987
2. OSMA Task Force on Professional Liability, Sept. 20, 1987
3. Young Physician's Committee, Sept. 26, 1987
4. OSMA Resident Physician Section, Oct. 17, 1987
5. OSMA/MSS Governing Council, Aug. 16 and Oct. 18, 1987
6. OSMA AIDS Task Force, Oct. 17, 1987

Department Reports

Mr. Campbell and Mr. Clinger each addressed the Council on activities and programs for their respective departments.

Councilor Reports

Each of the Councilors reported on activities of interest in their districts.

Legal Department Report

The Legal Department distributed a written report on its activities and it was filed. The Council then considered and approved proposed Bylaws change requested by the OSMA Hospital Medical Staff Section as follows:

"SECTION 11(b) A maximum of five resolutions, directly related to issues of specific concern to physicians on hospital medical staffs and matters of immediate importance, adopted by and presented from the business meeting of the hospital medical staff section

representative assembly, as provided in their bylaws, may be presented for consideration by the House of Delegates at any time before the opening of the House of Delegates. All other resolutions adopted by and presented from the business meeting of the representative assembly of the Hospital Medical Staff Section shall be submitted in report form to the House of Delegates at the following year's annual meeting of the House of Delegates for purpose of filing."

The Council then adjourned and pursuant to proper legal notice convened as the sole shareholder of the Physicians Administrative Corporation of Ohio. A resolution was presented to dissolve the PACO Corporation. It was approved and notice was ordered to be sent to the Secretary of State's office to cancel the corporation's registration.

Council reconvened and approved proposed county bylaws amendments from the following counties: Cuyahoga, Lawrence, Washington and Columbiana.

New Business

Dr. Irons reported on the appointment of a Medical Advisory Committee to assist the ombudsman in dealing with the Professional Review Organization (PRO).

Dr. Marshall discussed a patient advocacy program being implemented in a county in Indiana and asked the staff to research the feasibility of conducting a similar program in Ohio.

The Council went into a closed session.

A joint meeting of the Council with the deans of the medical schools was held on Sunday morning November 15, with issues of mutual interest being discussed.

Respectfully submitted,
Herbert E. Gillen
Executive Director

PICO: 1987 in Review

By Joseph Gilmore

PICO completed the difficult year of 1987 with increased assets, increased shareholders' equity (capital and surplus), strengthened loss reserves, and renewed confidence in the company's ability to achieve continuing and long-term success.

Two major happenings of the year impacted significantly on PICO's operations and Ohio physicians. The Ohio Department of Insurance, concerned over continued adverse trends in medical professional liability claims, expressed that concern by questioning the adequacy of reserves for future losses.

PICO and its independent actuaries, the national firm of Coopers & Lybrand, believe PICO's loss reserves are adequate for all future loss exposure.

Nonetheless, PICO initiated a loss reserve strengthening program, with the provision that if loss reserves at a future time prove to be greater than necessary, excess funds will be returned to PICO policyholders.

In June, an unexpected decision by the Ohio Supreme Court suddenly removed Ohio's statute of limitations on the filing of medical malpractice claims. PICO moved quickly to ascertain the additional loss exposure created by this landmark and made a special addition of \$8.1 million to loss reserves, effective during the second quarter of the year.

While this action resulted in an

operating loss for the second quarter and first half of 1987, PICO returned to profitability during the third quarter.

In October, another unexpected decision by the Ohio Supreme Court further liberalized Ohio's laws on the filing of medical malpractice claims, but PICO believes that its loss reserves are now adequate for any additional exposure.

The ramifications of these court decisions on Ohio physicians are of serious magnitude. PICO has joined forces with the OSMA in communicating to physicians the importance of maintaining all patient records, keeping a detailed file on past as well as current insurance protection, and other actions to prepare for potential claims arising from medical services provided in past years.

PICO's major subsidiaries continued to play an important role in the company's progress. American Physicians Life Insurance Company is now offering the OSMA Group Life Plan and Group Major Medical Plan on a package basis to the entire membership, including medical residents and students. Of course, either coverage may be obtained separately. APL's new life and disability insurance sales increased over the past year, and additional emphasis is being placed on retirement plans and pension administration and funding.

The Professionals Insurance

Company, which offers auto, homeowners and other property and casualty coverages, recorded new highs in premiums for those lines during 1987, and also implemented programs to increase profitability while remaining competitive. The Professionals also provides malpractice insurance for dentists, nurses and ancillary medical personnel, and offers claims made coverage to Ohio physicians desiring that form of protection.

PICO's other major subsidiaries, Raven Development Company, and SMB Financial Planning, Inc., contributed to the company's successful year. Raven has become established as a quality developer in the Central Ohio area, and SMB is recognized as a leader in fee-only financial planning services.

PICO's financial report to shareholders for the first nine months of 1987 graphically portrayed the company's strong market and financial position. Loss reserves were in excess of \$103 million, while consolidated total assets rose above \$214 million. Shareholders' equity was nearly \$28 million, or \$9.08 per share. Total revenues for the nine-month period were \$69 million.

During 1987, PICO transferred \$9 million in medical professional liability premiums being written through The Professionals to Physicians Insurance Company of Wisconsin, a new company owned

principally by Wisconsin physicians. PICO provides management services to the company, and has a minority ownership position. Wisconsin thus becomes the sixth state in which PICO has helped physicians to gain major influence on the medical professional liability climate. Other states include Kentucky, Michigan, Indiana and Florida.

In summation, 1987 was a year during which PICO met several major and unexpected challenges. The strengths established in 10 previous years of successful operations enabled the company to deal with these challenges, while

continuing to build on a solid base of experience, expertise and professionalism.

Most importantly, PICO continues to offer OSMA members the highest quality medical professional liability coverage, at adequate rates and with lifelong security assured by adequate loss reserves. Additionally, the PICO organization also provides the OSMA membership with equally high quality life, disability and health insurance, pension and retirement services, auto, homeowners and office protection insurance coverages, and financial planning services.

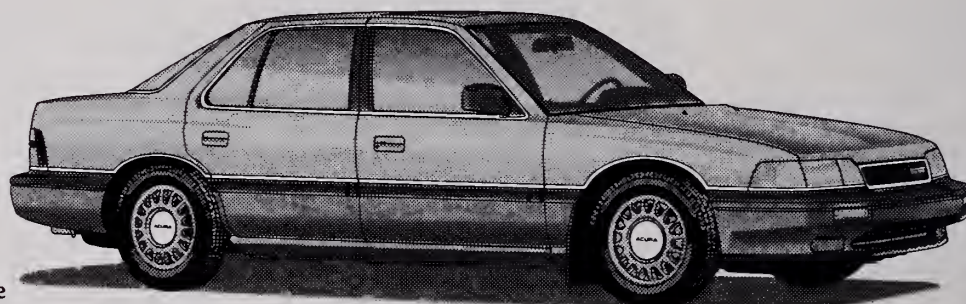
PICO is unique among the

nation's medical professional liability insurance carriers in the extent and nature of services provided. In partnership with the OSMA, PICO will expand its leadership in serving physicians. It is noteworthy that PICO enters 1988 as the only source of the highly desired occurrence form of medical professional liability insurance coverage, with limits in excess of \$1 million, for Ohio physicians. **OSMA**

Joseph Gilmore is the president of the Physicians Insurance Company of Ohio.

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AMA Market Area Profile Service (MAP)

This service helps physicians make informed marketing decisions regarding their area by providing detailed demographic and health resource information regarding the selected area. This includes: population, number and size of households, per capita income, unemployment rate, number and age of physicians, number of specialists, number of hospitals and description of facilities and services. This report is particularly helpful for physicians investigating a new site or comparing several sites, and for physicians planning to expand or modify services.

For information, write:
AMA Market Area Profile Service,
AMA, 535 North Dearborn Street,
Chicago, IL 60610.

AMA Marketing Workshops

The Competitive Edge: Practice Building Techniques for Today's Health-Care Market — Half-day workshop focusing on practical techniques to ensure a busy practice and a loyal patient following.

Marketing Strategies for Private Practice — A full-day workshop designed to help physicians position their practice to meet today's changing health-care climate.

For information, dates, locations and costs, call the AMA Department Registrar at (312) 645-4958 or write: AMA, Department of Practice Management, 535 North Dearborn Street, Chicago, IL 60610. **OSMA**

To order a free copy of the Physician's Marketing Handbook, contact the OSMA Dept. of Communications and Physician Marketing, 600 S. High, Columbus, Ohio 43215.

CONTINUING MEDICAL EDUCATION

April

Medical Progress for the Primary Care Physician

When: April 27, 28, 1988

Where: Bunts Auditorium,
Cleveland Clinic
9500 Euclid Avenue
Cleveland, Ohio 44106

CME Credit: 11 hours, Category I

Fee: \$190, Physicians;
\$140, Residents and
Nurses

Sponsor: The Cleveland Clinic
Educational
Foundation

Contact: Department of
Continuing Education
The Cleveland Clinic
Educational
Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
1-800-762-3172, Ohio
1-800-762-3173, outside
Ohio

Pediatric Update for the Practicing Physician

When: April 13, 1988

Where: Holiday Inn Cascade
Akron, Ohio

CME Credit: not given

Fee: not given

Sponsor: Children's Hospital
Medical Center of
Akron
Ohio Chapter/AAP

Contact: George A. Nankervis,
PhD, MD
Children's Hospital
Medical Center
281 Locust Street
Akron, Ohio 44308
216-379-8906

August

Fundamentals of Otolaryngology

When: August 7-12, 1988

Where: Kings Mill Inn

Kings Island, Ohio

CME Credit: 30 hours, Category I

Fee: \$575, Physicians;
\$400, Residents, Students

Sponsor: Department of
Otolaryngology and
Maxillofacial Surgery
University of Cincinnati
Medical Center

Contact: Donald A. Shumrick,
MD, Chairman
Dept. of Oto. and Max.
Surgery
UC Medical Center
M.L. #528
Cincinnati, Ohio 45267

International Doctors in Alcoholics Anonymous — Annual Meeting

When: August 3-8, 1988

Where: Stouffer Hotel
Baltimore, Maryland

CME Credit: not given

Fee: not given

Sponsor: International Doctors in
Alcoholics Anonymous

Contact: Information Secretary,
IDAA
1950 Volney Rd.
Youngstown, Ohio 44511
216-782-6216

May

New Revised Practical Radiology Review Course

When: May 16-20, 1988

CME Credit: Category I

Fee: \$350

Sponsor: Radiology Department
University of Cincinnati
College of Medicine

Contact: Harold B. Spitz, MD
Department of Radiology
University Hospital
234 Goodman St.,
M.L. #742
Cincinnati, Ohio 45267

The AMA Interim Report

By
Theodore J. Castele, MD, Chairman
Ohio Delegation to the AMA
and
D. Ross Irons, MD, President
Ohio State Medical Association and
Co-Chairman, Ohio Delegation to the AMA

This report covers some of the important issues voted on by the Ohio Delegation at the 1987 Interim Business Meeting of the American Medical Association in Atlanta, Georgia, December 6-9, 1987.

There were 73 reports and 144 resolutions considered by the House of Delegates.

AMA Campaign Activities

The AMA House of Delegates adopted the following resolution which was submitted jointly by eleven state delegations, including the Ohio Delegation to the AMA:

"RESOLVED, That all candidate support activity at American Medical Association meetings be limited to hospitality suites or public meeting rooms no larger than the largest suite within the headquarters hotel; and be it further

RESOLVED, That no state or coalition have more than two

nights of hospitality; and be it further

RESOLVED, That large events with bands, entertainment and decorations be eliminated; and be it further

RESOLVED, That the state where the AMA meets should feel no obligation to sponsor a "host state party."

Specialty Organization Representation in the House of Delegates

The AMA House of Delegates adopted a Council on Constitution and Bylaws report that amends the AMA Bylaws regarding admission of Specialty Organization to representation in the AMA House of Delegates. In these amendments, the title of Chapter 8 of the AMA Bylaws has been changed to reflect the Long Range Planning Council's designation of "Specialty Organizations" rather than "Specialty Societies." The

chapter has been extensively rewritten, not only to implement the changes required by adoption of the Council on Long Range Planning and Development Report A (A-87), but also to eliminate certain sections that were originally drafted for the purpose of commencing specialty representation in the House of Delegates but which are no longer necessary. Additionally, the amendments include a stipulation requiring specialty organizations represented in the House of Delegates to reconfirm their qualifications for representation every five years by establishing that they continue to meet the necessary guidelines.

Ethical Issues Involved in the Growing AIDS Crisis

The AMA House of Delegates filed a Council on Ethical and Judicial Affairs report that provides ethical guidelines on three

important issues relating to the AIDS epidemic. A summary of the three guidelines are as follows:

1. A physician may not ethically refuse to treat a patient solely because the patient is seropositive.
2. Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive patient is endangering a third party, the physician should:
 - a. attempt to persuade the infected patient to cease;
 - b. if persuasion fails, notify the authorities;
 - c. if the authorities take no action, notify the endangered third party.
3. A physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others.

Do Not Resuscitate Orders

The AMA House of Delegates filed a Council on Ethical and Judicial Affairs report that recommends that hospital medical staffs, with the approval of governing boards, adopt statements of policy regarding do not resuscitate (DNR) orders. The report further recommends that DNR policies should be based on medical, ethical, legal and community standards and should be consistent with any religious principles adhered to by the hospital.

A National Study of Resource-Based Relative Value Scales for Physician Services: A Status Report

The AMA House of Delegates filed a Board of Trustees report that presents a status report on the Association's involvement in a national study of resource-based relative value scales for physician services. The study is being

conducted by Harvard University, with major funding being provided by the Health Care Financing Administration. The AMA is providing technical support and is participating on the advisory board.

The initial goal of the project is to develop a resource-based RVS for each of the 17 specialties studied thus far: allergy and immunology, anesthesiology, dermatology, family medicine, internal medicine, obstetrics and gynecology, ophthalmology, orthopedics, otolaryngology, pathology, pediatrics, psychiatry, radiology, rheumatology, surgery, thoracic surgery, and urology. The second goal is to develop a national resource-based RVS across specialties. Development of an accurate method to link the specialty specific RVS's will be crucial to the successful attainment of this goal.

As reported at earlier meetings of the Association, the AMA has taken an active role in the study. In summary, the AMA has:

- assured physician involvement in the study through the nomination process for the Technical Consultant Groups and by the provision of names from the Physician Masterfile for the national physician survey;
- furnished data and analyses to Harvard on practice costs and patterns from the Socioeconomic Monitoring System, on CPT-4 codes, and on key aspects of the project's methodology;
- assisted national medical specialty societies in obtaining additional funding;
- consulted on the design and implementation of the study;
- communicated with national medical specialty societies through such means as two meetings in Chicago; periodic memoranda from James H.

Sammons, MD, AMA Executive Vice President; and frequent staff discussions; and —had James S. Todd, MD, AMA Senior Deputy Executive Vice President, serve on the project's Advisory Committee.

Use of the Harvard/AMA RVS in a Medicare fee schedule system currently appears likely. However, several issues still must be addressed by the AMA, including the possibility of gradual implementation, monetary conversion factors to change the RVS to physician payments, updating mechanisms for both the RVS and conversion factor, and specialty and geographic variations.

The Board remains convinced that an RVS resulting from this study could be the basis for a Medicare physician reimbursement system that would be acceptable to the federal government, Medicare beneficiaries and medicine. The Board continues to emphasize, however, that the AMA is not committed to support any RVS implementation that would violate AMA policies, especially the Association's long-standing position against mandatory acceptance of third-party payments as payment in full. The Board will continue to inform both the House of Delegates and the Federation about the progress of the Harvard/AMA RVS project. In addition, the Board will notify the House of proposals to implement an RVS resulting from this project, and it will work to ensure that any such implementation is in accord with AMA policy.

The House of Delegates also adopted the following resolution on this subject:

Harvard Relative Value Scale Study

“RESOLVED, That the American Medical Association continuously monitor the progress of the Harvard Relative Value

Scale (RVS) Study and report to the membership and the House of Delegates; and be it further

RESOLVED, That the AMA continue to review thoroughly the data and process being employed in the RVS Study and report on this to the membership and the House of Delegates; and be it further

RESOLVED, That, where appropriate, the AMA seek changes before completion of the study when defects or deficiencies are identified in the data or process employed; and be it further

RESOLVED, That the AMA work to ensure fair treatment of all medical specialties by obtaining input from these groups prior to the publication of the Harvard RVS Study, and that, after the study's publication, the AMA work to ensure that the Harvard RVS study is equitably applied."

In addition, the House of Delegates referred the following three resolutions to the Board of Trustees for action:

Relative Value Study

"RESOLVED, That the American Medical Association Board of Trustees develop criteria by which the Relative Value Study can be evaluated, seeking input from the various national specialty organizations and such criteria be provided for review by the members of the House of Delegates as soon as available but no later than the 1988 Annual Meeting; and be it further

RESOLVED, That the Board of Trustees develop recommendations for implementation of the Relative Value Study, assuming acceptance by the AMA, to include both specific methodology and time to achieve full realignment."

Relative Value Scale for Physician Services

"RESOLVED, That it is the policy of the American Medical Association that any schedule of

allowance or relative value scale adopted as a method of payment under Medicare must uniformly and consistently apply to services rendered by physicians in all specialties; and be it further

RESOLVED, That the AMA strongly oppose development and implementation of separate schedules of allowances or relative value scales for certain specialties or subsets of physician services as methods of payment under Medicare; and be it further

RESOLVED, That the AMA promptly initiate a dialogue with specialty societies in support of these policies."

AMA/Harvard Relative Value Study

"RESOLVED, That the American Medical Association Board of Trustees, upon receiving the final report of the Harvard/AMA Resource-Based Relative Value Study, carefully review and evaluate this report, transmitting the Board's conclusions and recommendations to the AMA House of Delegates for final action regarding AMA policy on this study."

MAACs: Current Status

The AMA House of Delegates filed a Council on Medical Service report that describes AMA activities to correct inequities in Medicare's Maximum Allowable Actual Charge (MAAC) limits. Among the reasons for discrepancy between physician and carrier-calculated MAACs are:

- The use by carriers of the *median* of physician charges during the April-June 1984 base period, rather than the *weighted average* used by many physicians to make their own calculations so as to minimize any rollback in their allowable charges. Carriers are required to recognize a MAAC based on either figure.
- Carriers erroneously requiring *three* charges during the base

period to compute the MAAC for a service; only *one* physician charge for the services is required to compute the MAAC.

- Coding errors resulting from the carriers' conversion of charge date from 1984 services to the now-mandated CPT-4 procedural coding system. In a meeting held with an HCFA representative late last summer, the AMA received the following information:
 - HCFA transmittals to carriers have clarified the data needed and the process to be followed by carriers in calculating MAACs, as well as the types of information which should be available on request to physicians electing to calculate their own MAACs. Physicians will continue to be allowed to calculate their own MAACs and to use the weighted average of charges, if desired.
 - The process of reconciling current CPT-4 procedural coding with 1984 charge data has been largely completed, and carrier errors from this source should be minimal in the future.
 - No sanctions have been imposed on physicians for charges in excess of MAACs to date; rather, carriers have been monitoring and alerting those physicians whose charging patterns indicate the possibility of their average charge for a service exceeding the appropriate MAAC at the year's end.
 - Barring any major changes in the methods or sources of charge data for calculating MAACs which may be required by budget reconciliation legislation presently under consideration in Congress, HCFA expects that carriers will provide physicians with their MAACs for purposes of 1988

charge limits by October 1 of 1987; decisions regarding participation must be made by December 31.

There may be changes in MAAC calculation methodology and implementation imposed by the budget reconciliation provisions finally enacted. Legislative revisions adopted by the House Energy and Commerce Committee at the time this report was written would allow physicians without actual charges for a service during the April-June 1984 base period to use established charges for the year ending March 31, 1984, in determining their MAAC. A provision reported out by the House Ways and Means Committee would similarly allow use of pre-April 1984 charges in determining a MAAC in such situations. Another Ways and Means provision would impose the MAAC as a flat limit on each individual charge, rather than on the average yearly charge for a service as now allowed. The Senate Finance Committee will consider budget reconciliation provisions after the August Congressional recess.

In addition to seeking outright repeal of MAAC provisions, the AMA, as an interim step, has also proposed legislative amendments that would allow calculation of MAACs based on the physician's current customary charge profile for the period July 1985-June 1986.

In addition, the House of Delegates adopted the following resolutions:

Medicare — MAAC

“RESOLVED, That the American Medical Association seek specific legislation to eliminate unfair fee distortions created by the current Maximum Allowable Actual Charge (MAAC) implementation.”

Medical Maximum Allowable Actual Charge Violation Reporting

“RESOLVED, That the American Medical Association continue to make every effort to prevent physicians from being penalized, persecuted or prosecuted for unintentional possible Medicare Maximum Allowable Actual Charge (MAAC) violations; and be it further

RESOLVED, That the American Medical Association continue to make every effort to relieve physicians of the inequitable MAAC provisions which serve no useful purpose either for government, patient or physician; and be it further

RESOLVED, That the AMA continue to make every effort to effect the elimination of the artificial and misleading categorization of physicians as “participating or “nonparticipating.”

MAAC Discrimination Against Young Physicians

“RESOLVED, That the American Medical Association seek to correct the discriminatory practice of the Health Care Financing Administration in the implementation of Maximum Allowable Actual Charges (MAACs); and be it further

RESOLVED, That the AMA adopt a policy that the MAAC, for a given service or procedure in a given region of the country, be nondiscriminatory with respect to time in practice.”

Notification to Patients of Charge Amounts Prior to Service as per Omnibus Reconciliation Act of 1986

“RESOLVED, That the American Medical Association oppose efforts by commercial carriers or the federal government which would require physicians to predict reimbursement for services rendered; and be it further

RESOLVED, That specifically the American Medical Association continue to work for the repeal of the provision of the Omnibus

Budget Reconciliation Act of 1986 (OBRA) regarding notification of patients receiving elective surgery of the physician charge, the expected amount of Medicare reimbursement and the balance that the patient would be responsible for paying when the charge for the service is \$500 or more and the claim is not accepted on an assigned basis; and be it further

RESOLVED, That the AMA continue to work to repeal those provisions of OBRA that require physicians to refund payments associated with Medicare services that are deemed medically unnecessary by HCFA after the fact; and be it further

RESOLVED, That the AMA communicate to the federal government that increases in Medicare reimbursement need to be universal, that current reimbursement be adjusted, and that there should be no discrimination in schedules between participating and nonparticipating physicians.”

Report of the Special Task Force on Professional Liability and Insurance and the Advisory Panel on Professional Liability

The AMA House of Delegates adopted a Board of Trustees report which notes the continuing problems associated with professional liability, describes recent federal activity in this area, and describes recently developed alternatives to the civil justice system. The report further discusses risk retention groups, procedural based insurance rating plans, and the availability of Directors and Officers liability insurance, as well as recent AMA activity addressing professional liability.

In addition, the House of Delegates adopted the following resolution:

Judicial Review of Tort Reforms

“RESOLVED, That the

American Medical Association compile a report of the state tort reforms that have been lost in each state through judicial review in the past fifteen years; and be it further

RESOLVED, That such report be submitted annually to the House of Delegates as long as the liability crisis continues."

Resident Physician Working Hours and Supervision

The AMA House of Delegates adopted a Council on Medical Service report in lieu of two resolutions. The report, which presents a comprehensive review of resident working hours and supervision, recommends that:

"1. The AMA recognize that problems exist with regard to resident working hours and with resident supervision, which may compromise the educational program, the health of residents, and patient care;

2. The AMA urge the Accreditation Council for Graduate Medical Education to revise the Essentials of Accredited Residencies in Graduate Medical Education to emphasize the importance of the principles concerning resident supervision, work hours and stress so that quality patient care, patient safety and resident education will be optimized, and to direct AMA appointees to the Accreditation Council for Graduate Medical Education to work toward the achievement of these revisions.

3. The AMA urge each Residency Review Committee to revise its Special Requirements to define the supervision and the maximum work hours to avoid excessive stress and fatigue, to assure quality patient care, and to attain the objectives of the educational program. The definition of maximum work hours might specify that on-

duty assignments should on average be no more frequent than every third night and that there should on average be one 24-hour off-duty period every seven days. The Council emphasizes that these periods are suggestions only and that each Residency Review Committee must determine the appropriate rules for its own specialty. AMA appointees to Residency Review Committees should be directed to work toward the implementation of this recommendation. Furthermore, the duration of training programs should be based on the changes that occur in the scope and content of specialties, not solely on changes in supervision or working hours.

4. The AMA urge each Residency Review Committee to require, as evidence of compliance with the General and Special Requirements, that each program director review the supervision of residents and the scheduling of residents' activities; and that AMA appointees to Residency Review Committees be directed to work toward the implementation of this recommendation. The program director's review must assure the existence of support systems that will provide appropriate supervision and work schedules to avoid chronic or excess stress and fatigue for residents. In institutions with several programs, program directors should be required to cooperate in this review and demonstrate institutional responsibility for support systems to avoid chronic or excessive stress and fatigue for residents. Residency Review Committees should give particular attention to

residency programs that require many hours of intense responsibility.

5. The AMA policy be that these problems should be addressed within the present system of graduate medical education without regulation by agencies of government."

Hospital Corporate Bylaws

The AMA House of Delegates adopted the following resolution:

"**RESOLVED**, That the American Medical Association encourage hospital medical executive committees and/or their legal counsel to regularly examine the hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices; and be it further

RESOLVED, That the AMA encourage hospital medical executive committees to request their hospital board of trustees/directors notify them of any proposed or impending changes in the hospital/corporate bylaws; and be it further

RESOLVED, That the AMA encourage hospital medical executive committees to advise members/applicants of the medical staff of the effect of these hospital/corporate bylaws, rules and regulations."

Hospital Medical Directors Designated as the Representatives of the Medical Staff

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED**, That the American Medical Association work with state medical associations to oppose the enactment of any governmental regulations, such as those currently under consideration in the state of New York, which would mandate that every hospital governing body appoint a medical director who would have authority over the medical staff."

AMA Response to Hospital Governing Bodies in Challenging Medical Staff Self-Governance

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association reaffirm its policy in support of medical staff self-governance, including the process of electing and seating officers of the staff in accordance with the medical staff bylaws, and its policy opposition to improper interference by the governing body in that process; and be it further

RESOLVED, That the AMA work with State Hospital Medical Staff Sections, state medical societies and individual medical staffs to support medical staff self-governance in appropriate situations."

AIDS Education

The AMA House of Delegates adopted a Council on Scientific Affairs report which recommends that the AMA support AIDS education in the United States by:

1. Encouraging national coordination and tracking of all major AIDS health education and prevention activities.
2. Encouraging the federal government through AMA policy statements and recommendations to increase funding for prevention and education significantly in accordance with Public Health Service Projections of the incidence of HIV-related disease.
3. Encouraging the federal government through AMA policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based upon real and measurable needs.
4. Organizing, in collaboration

with other groups, a national conference aimed at developing strategies and recommendations for AIDS education in the United States.

5. Developing and facilitating by all methods available to the AMA educational resources and effective delivery programs for the following specific groups: Youth who attend school (including secondary school) and those who do not; homeless and runaway youths; college students and other young adults; intravenous drug users; minority groups, especially blacks and Hispanics; public workers; prostitutes; institutionalized and non-institutionalized offenders; health-care workers who provide service to HIV-infected/symptomatic persons; homosexual and bisexual males; women of child-bearing age; and sexual partners of high-risk persons.
6. Encouraging physicians to assist parents in providing human sexuality education to children and adolescents.

Establishment of AMA AIDS Task Force

The AMA House of Delegates adopted a Board of Trustees report that responds to an earlier resolution calling for the establishment of a Task Force to study AIDS. The report notes that an AMA AIDS staff task force was established in 1985 for the purpose of examining pertinent issues, coordinating activities, and ensuring that the AMA is responsive to the growing AIDS crisis. The report further discusses the broad range of the AMA's ongoing activities regarding AIDS and concludes the intent of the resolution is being met in an efficient and comprehensive manner by the Board of Trustees itself, the existing AIDS staff Task Force and a panel of expert

consultants.

Assessing the Impact of AIDS on Residency Training

The AMA House of Delegates referred the following resolution to the Board of Trustees for action:

"RESOLVED, That the American Medical Association encourage the study of the impact of AIDS on residencies which currently provide patient care and pre- or post-mortem diagnostic services to AIDS patients, particularly the impact on education, stress and psychosocial adaptation of residents; as well as investigating model programs for constructive responses to this crisis."

Accuracy of the ELISA and Western Blot Serologic Tests for HIV Infection

The AMA House of Delegates adopted an amended Council on Scientific Affairs report that reviews the performance characteristics of the Elisa and Western Blot tests for HIV. The report concludes that it is likely that anyone who is clearly both ELISA and Western blot positive is infected with HIV. Persons who are ELISA positive and Western blot indeterminate should be tested again on a second serum sample. Persons who are ELISA positive and Western blot negative are probably truly negative if they are members of low-risk groups (the majority of the world population). If such people are members of high-risk groups or if their risk status is unknown, the Western blot test should be repeated on the same serum sample. If the test is still negative, then the individual should be tested again in three to six months.

Prevention of HIV Transmission in Prisons

The AMA House of Delegates referred the following resolution to the Board of Trustees:

"RESOLVED, That the American Medical Association

recommend that all federal and state prisoners not be subjected to mandatory HIV testing upon entering the penal facility; and be it further

RESOLVED, That the AMA submit a report on HIV testing for prisoners at each Annual Meeting of the House of Delegates in the light of current scientific data concerning incidence and prevalence of the problem in American prisons and jails."

Financing of Care for AIDS — the HIV Epidemic

The AMA House of Delegates adopted a Council on Medical Service report that addresses the critical issue of whether the private insurance market and existing public programs can adequately provide health expense protection to HIV-infected persons and persons with AIDS. The report concludes that these programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage. However, as the disease patterns and costs become more defined, it may become necessary to reevaluate this conclusion. Continued study is imperative.

Medical Implementation of SI Units

The AMA Board of Trustees adopted an amended Board of Trustees report that concludes that the AMA should not promote mandatory conversion to SI units at this time but should continue to educate physicians regarding the SI unit system through its publications. The *Journal of the American Medical Association* and the AMA specialty journals, which began conversion to SI units in 1986, will continue the conversion process.

Report on Thermography

The AMA House of Delegates adopted the following amended resolution:

"**RESOLVED**, That the House of Delegates affirm that it has not requested and has not adopted any official policy statement or position of the American Medical Association on the use of thermography; and be it further

RESOLVED, That, in light of the numerous issues aired, the House of Delegates requests the Board of Trustees to ask the Council on Scientific Affairs to reconsider its report on thermography."

Mammography

The AMA House of Delegates referred the following resolution to the Board of Trustees for a report back to the House of Delegates:

"**RESOLVED**, That the American Medical Association undertake a physician education program which will strongly urge physicians to refer women for mammograms."

AMA Specialty Journals

The AMA House of Delegates adopted a Board of Trustees report in lieu of a resolution on this subject. The report outlines the rationale underlying the decision to place the AMA's specialty journals on controlled circulation beginning in 1988. This means that publications will be distributed without charge to the specialists and subspecialists for which each journal is published, regardless of the AMA membership status of the recipient. The journals will be available to others on a subscription basis with a deep discount offered to AMA members.

FMG Participation

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED**, That the American Medical Association offer encouragement and assistance to state and county medical societies in fostering greater participation of foreign medical graduates in leadership

positions at all levels of organized medicine by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among FMGs.

Trends in Health Delivery Systems

The AMA House of Delegates filed an amended Board of Trustees report that discusses the Board's ongoing monitoring of the development of health-care delivery systems and presents current trends in delivery systems. The report notes that the nation's 654 HMOs currently serve an estimated 11 percent of the population. The exact number of PPO enrollees is undetermined, but the percentage actually covered by PPOs is estimated to range from 5 to 8 percent of the population. Both HMO and PPO arrangements are growing and are expected to claim a larger share of the health-care market. While the impact on other forms of health-care delivery has been significant, the majority of the population still receives health care through the fee-for-service sector. The Board will continue to monitor health-care delivery trends, especially at the state and county medical society levels, and keep the House of Delegates apprised on a regular basis.

Appropriate Compensation for HMO Patients

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED**, That the American Medical Association seek from the Health Care Financing Administration regulations that would require prepaid managed health-care organizations to compensate non-contracting hospitals and physicians appropriately for bona fide emergency care including federal or state mandated screening or evaluations rendered

to their enrollees, and require that Medicare enrollee cards provide identification of the prepaid program in which the patient is enrolled.

There are many excellent reports presented to the House of Delegates at each meeting covering a wide range of subjects that are of interest to physicians. These reports, prepared by the AMA Board of Trustees, councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follow. If you would like a copy of these reports, please contact the OSMA Department of Development and Member Services.

1. Papanicolaou Tests in Healthy Women
2. Health IRAs
3. Smokeless Tobacco
4. Membership Incentive Program
5. Protecting the Uninsured: Use of State Risk Pools
6. Guidelines for Quality Assurance
7. Health Insurance Coverage of Psychiatric Illness
8. Access to Care in Rural Areas
9. Firearms as a Public Health Problem in the United States: Injuries and Death
10. Cancer Risk of Pesticides in Agricultural Workers
11. Smoking Cessation

DOCTOR, is it time for a change?

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Please send me the following AMA report(s) listed in the Summary of Actions Report of the 1987 AMA Interim Meeting:
Report Number(s) _____

Name: _____

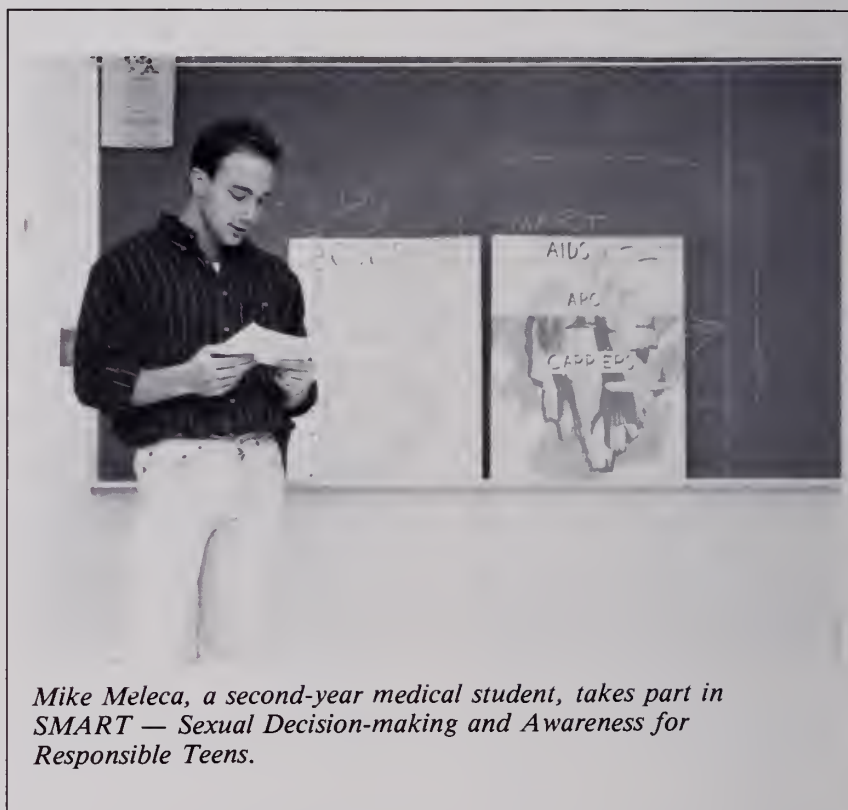
Address: _____

Send to: OSMA Department of Development and Member Services
600 S. High Street
Columbus, Ohio 43215

Help for the Adolescent Health Crisis

By Cindy Smith

The student leaders of the Ohio State Medical Association Medical Student Section (OSMA-MSS) and the American Medical Association-Medical Student Section (AMA-MSS) have recently become interested in programs which use medical students to educate high school, junior high and elementary students. Medical students are in the unique position of being approachable as peers (especially for high school students) while being knowledgeable on medical topics. The OSMA-MSS is running a statewide Student-Student program this year, which was featured in previous issues of *OHIO Medicine*. The Medical College of Ohio at Toledo, the school that piloted the Student-Student program, has continued to expand its program this year. Wright State University medical students have successfully started the Student-Student program in Dayton and students at NEOUCOM are in the process of organizing their program. Medical students at Ohio State University and the University of Cincinnati are involved in two very dynamic



Mike Meleca, a second-year medical student, takes part in SMART — Sexual Decision-making and Awareness for Responsible Teens.

programs which are reaching out to Columbus and Cincinnati high school and junior high students.

The program at Ohio State is called SMART (Sexual Decision-making and Awareness for Responsible Teens). The program is directed at junior high students because they are just moving into peer group influences. Ohio State medical students have run the SMART program for three years.

This year the program is being co-sponsored by AMSA (American Medical Student Association) and the Columbus chapter of the March of Dimes.

SMART is an intensive six-day program. Three medical students serve as educators for each classroom. The medical students spend 40-45 minutes per day with the students, addressing a new topic each day. Day one: the topic

is decision-making skills. The students are asked, "What are some good reasons to have sex?" Answers are written on the board: love, it feels good, to have a baby. The students are asked, "What are some bad reasons to have sex?" Answers: peer pressure, diseases. The entire session is interactive. Students discuss responsibilities and look at consequences. Day two: The topic is puberty with a focus on anatomical and physiological changes, nutrition, and the effects of drugs and alcohol on the body. Day three: STDs. Day four: AIDS, with a very basic explanation of the immune system. The focus of the discussion is on transmission and prevention. Day five: Birth control methods are discussed with the help of models. Day six: Teen pregnancy with a focus on responsibilities and expectations. Day seven: A guest panel of teenage parents come in to talk about what parenting is *really* like. Medical students answer questions that students have written down anonymously all week on index cards. The coordinator of this year's SMART program is a second-year student, Robin Frye. She is coordinating the training and efforts of 60 first- and second-year students who are serving as educators in the program.

Each junior high student who participates in the program receives a folder full of pamphlets and information on all of the topics discussed as well as a comprehensive list of phone numbers to call for help or further information. The program will reach 400 junior high school students in Columbus this year. Next year, depending on funding, SMART plans to reach 1,000 students.

At the University of Cincinnati, medical students are speaking to high school and junior high students through a Speakers Bureau run by the University of Cincinnati Chapter of Doctors Ought to Care (DOC). The Speakers Bureau was started in the

spring of last year and 10 presentations were given during 1987. This year 15 presentations have already been given and the program coordinator, Jim Gebel, hopes to reach 1,000 to 3,000 students this year.

The program offers talks on drug abuse, alcohol abuse, sex education, AIDS, STDs, and an impressive slide program on smoking. The focus is on using humor and innovative ideas to reach students. Medical students are currently working on a music video about smoking. The program is trying to get across the message that smoking and drugs are not socially acceptable. At least 100 University of Cincinnati medical students will be involved with the Speakers Bureau by the end of the year. The University of Cincinnati Chapter of the OSMA-MSS is working with Jim Gebel and DOC to coordinate an expanded Speakers Bureau-

Student-Student effort to reach as many schools as possible in the Cincinnati area.

Plans are underway for a conference in the spring to bring together the leaders of programs such as SMART, DOC Speakers Bureau and OSMA-MSS Student-Student. The conference will allow medical students to share ideas and materials that they are using to reach high school, junior high and elementary students. It is obvious from the enthusiastic response from educators and community leaders to these programs that medical students can play an important role in the adolescent health crisis by using their training to educate other students. **OSMA**

Cindy J. Smith is a second-year medical student at Wright State University's School of Medicine.

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It's Not Easy Being Green

By A. Robert Davies, MD

“It’s not easy being green!” Somewhere in the recesses of memory are those words from a Muppet movie in which Kermit the frog laments some of the advantages and disadvantages of being green. It is a pleasant memory related to sharing an event with one of my now-adult children; a family memory shared with loved ones. Kermit sings of the downsides of “frogness,” but in the end sees the upside advantages of being himself as worth the humiliation and risks.

It’s not easy being involved in organized medicine, either, Kermit! Dr. Ted Castele and I were talking about this the other day and he said his son, recently in practice, read him the riot act about the ineffectiveness of the activities of organized medicine. “Even in my own family I have a credibility problem when it comes to AMA/OSMA activities!” is a statement which approximates a direct quote. I have experienced the same credibility problems in my own medical “family,” the county society. Too often the

messenger gets shot for bringing the message, or at least is associated with the message in a way which seems as if he agreed with its content. By the time we explain what has happened to us as practicing physicians or what is about to happen to us, there is little patience for hearing what didn’t happen because of the efforts of organized medicine.

In the same sense that it is difficult to get credit for efforts in preventive medicine (a person hardly notices that they don’t get polio these days), it is difficult to explain the importance of what didn’t happen in Washington or in the halls of our state legislature. We don’t have a curb on the contingency fee concept, but we do have a new set of rules to work with which are no worse and perhaps better than the ones we have had in the past. We don’t have medical licensing tied to accepting Medicare assignment in this state, and the practice of nursing has not been redefined to include medical diagnosis and treatment. We don’t have federally mandated doctor’s DRGs or a

payment system in which the doctor fee and the hospital payment are all wrapped up in one bundle (“you all just divide it among yourselves!”). We do have some things which none of us like and these are the items which stand out.

As Ted and I talked, we decided that if we worked all night putting AMA/OSMA sand bags in the path of the flood and contained the rising threat at Third Street, there would be those who would want to know why we let First Street get wet.

One of the reasons for the gap in credibility and understanding has to do with the stark realities of medical care delivery and finance and the rapid change which has occurred in our national economy. The more one learns about these issues the more one sees the impossibility of a quick fix. Perhaps the best we can do just now is to try to keep up with the changes and try to keep others from applying a quick fix which will be worse for all of us. By “us” I mean us doctors, us

continued on page 240

Employment Opportunities

ANESTHESIOLOGIST: Fulltime, incorporated practice. 400-bed hospital, all types of anesthesia. We presently have 5 anesthesiologists and 10 nurse anesthetists. Liberal fringe benefits, retirement plan and vacation. Good remuneration. Please reply to: EAS, Inc., East River Medical Building, 436 East River Street, Suite 2, Elyria, Ohio 44035.

A FRIENDLY COMMUNITY in West Central Ohio is seeking a Family Practitioner to join their established clinic. The position offers: a well-equipped facility with X-ray and laboratory, and a negotiable financial package tailored to the individual physician, including a salary range in the 70s, and many other benefits. The clinic is located in a small community just 20 minutes from picturesque Troy, Ohio and 30 minutes from Dayton, Ohio. Contact: Harold Lilly, VHA Physician Placement Services, 1600 Embassy Square Blvd, Suite 1605, Louisville, KY 40299, (502) 491-8311.

489 IM — Busy internist/cardiologist seeks an associate/partner. Practice is rapidly expanding and three established practices have recently been acquired. 800-bed tertiary care center nearby. Dynamic community of 350,000 with easy access to Chicago, Detroit and Cleveland. Contact Kevin Duffy, VHA Physician Placement Services, 1600 Embassy Square, Suite 1605, Louisville, KY 40299, (800) 626-1857.

CENTRAL OHIO, multispecialty group has opportunities available for BC/BE physicians in Pediatrics, Dermatology, Allergy, Neurology. Reply Box 181, c/o OHIO Medicine, 600 S. High Street, Columbus, Ohio 43215.

COLUMBUS, OHIO: Primary care physicians needed to staff urgent care facilities. Competitive salary, full benefits. Respond with CV to Paul Zeeb, MD, Medical Director, Primary Medical Associates, Inc., 340 E. Town St. #7-250, Columbus, OH 43215.

COLUMBUS — General Psychiatrist — Energetic Board eligible or certified psychiatrist sought for rapidly expanding private practice. Inpatient, outpatient and

consultation liaison duties. Opportunity for teaching and possible university appointment. Competitive salary and benefits. Send CV or inquiries to C.O.P.A., 130 S. Davis Ave., Columbus, Ohio, 43222.

EMPLOYMENT OPPORTUNITY. I need an internist with interest in cardiology, experienced and able to perform temporary pacemaker, Swan ganz catheter, etc., to join another internist in private practice in S.E. Ohio. Comprehensive salary and benefit package. Reply Box #175, c/o OHIO Medicine, 600 S. High Street, Columbus, Ohio 43215.

ENDOCRINOLOGIST

An established and progressive five-physician internal medicine group with emphasis on subspecialty practices is seeking an associate who is BC/BE in medical endocrinology.

Located in Fort Myers, Florida, a growing regional center for health care. This area has been attracting young professionals for over 10 years. The community has immediate access to a hospital with a progressive diabetes center.

Send CV to: Sergio Mather, MD, c/o Internal Medicine Associates, 3800 Evans Ave., Fort Myers, FL 33901.

Interested persons may also contact Dr. Mather at (813) 936-1343 or Diane Barnes at (813) 433-5006.

FAMILY/GENERAL PRACTICE. Immediate position open for Family Practice or Internal Medicine. Fully staffed, fully equipped, excellent opportunity, competitive salary, malpractice coverage and health insurance included. Practice leading to early partnership or ownership. Terms negotiable. Send CV to PO Box 4375, Warren, OH 44481, or call collect at (216) 399-1864.

FAMILY PHYSICIANS: Rent-free office bldg, equipment, staff furnished. Fee-for-service, coverage. Modern hospital. OB preferred. Call (614) 622-7497 or CV to: Village Medical Clinic, 1814 Enslee Rd, Coshocton, OH 43812.

FAMILY PRACTITIONER — Immediate opening in established rural clinic affiliated with West Central Ohio multi-hospital system. Excellent salary plus fringes. PO Box 631, Vandalia, OH 45377-0631.

FAMILY PRACTICE/INTERNAL MEDICINE — Physician wanted to join busy, established family practitioner. Excellent practice facility for acute and continual primary care. All administrative and practice expense furnished. No capital investment required. Base salary with productivity bonus and compensation package. Excellent income potential. Hospital and excellent school system with community college, two major lakes and recreation areas. Rural community with small industries, less than one hour from three metropolitan areas. Send CV — Davis S. Ayres, MD, 1400 North High Street, Hillsboro, OH 45133.

FAMILY PRACTITIONER (BE/BC)

Excellent central Ohio private practice solo opportunity. Modern progressive hospital sponsorship with income guarantee, rent subsidy, relocation expenses and cross coverage. All the advantages of small community lifestyle, excellent schools, and multiple recreation opportunities within an hour of Columbus amenities. Fully equipped state-of-the-art hospital with wide range of specialty services. Please send CV reply to: Box 178, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215.

FAMILY PRACTITIONER wanted to join a busy, established practice in Northwest Ohio, town of 10,000 with a 50-bed modern hospital. Must be interested in full spectrum of family practice with OB experience. Excellent practice opportunity with competitive financial package — salary, incentives, fringe benefits and malpractice insurance. For more information, send CV to Box 177, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215.

GASTROENTEROLOGY — Immediate opening for board-eligible gastroenterologist. Affiliated with West Central Ohio multi-hospital system. Excellent salary/guarantee plus fringes. PO Box 631, Vandalia, OH 45377-0631.

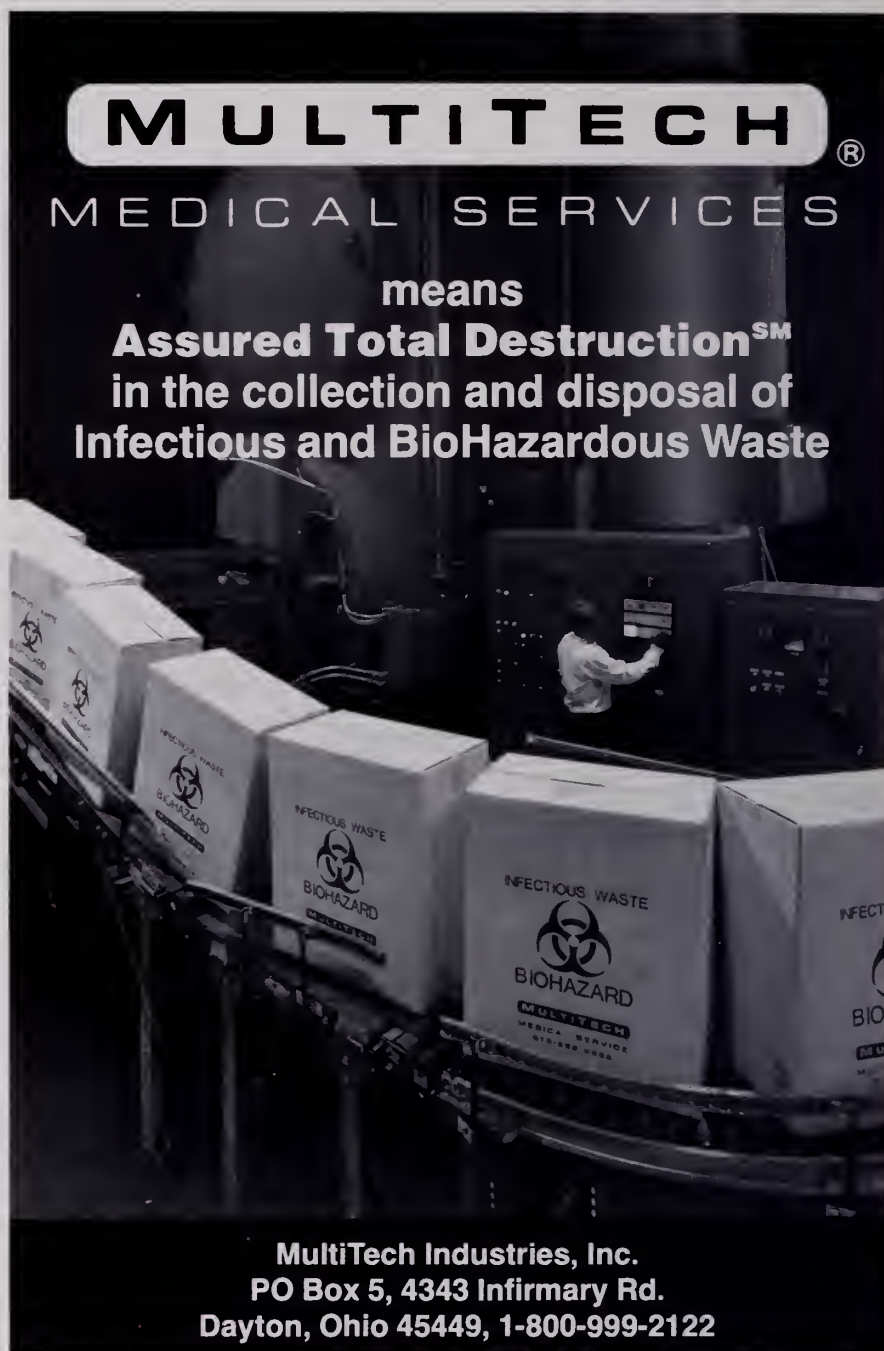
**Next month . . . place
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patients, us getting-older-too-fast senior citizens, us new-in-practice people, us legislators, us Democrats and us Republicans. If we in organized medicine can come up with some new ideas on how to structure the future (see the health policy agenda for the American people, AMA copyright 1987) then we'll try hard to effect some long-term improvement.

I don't think Kermit has said it yet but it is true that "the thing about change is you can count on it being different." As the future races toward us you can bet it will not look exactly like the good old past. We in organized medicine can't preserve the past but we have a chance at shaping the future. This is where you come into the picture.

If we worked all night to contain the flood on Third St., others would want to know why we let First St. get wet.

1. Please don't shoot the messenger!
2. Give organized medicine some good words from time to time. Without the AMA and the OSMA, things would be a whole lot more messed up for everyone.
3. Put your money where your mouth is. You may not realize it but your mouth in Washington and Columbus is the AMA/OSMA.
4. If your mouth doesn't seem to be saying what you think it should, get involved, get the facts and get into the act.
5. To all those who do not belong to the organized house of medicine, enjoy the trip; we've paid the fare. Please don't complain if you wind up in a place you didn't choose.



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It's not easy, but on balance, working in the bright light of the AMA and OSMA beats sitting in the shade and cursing the darkness. It's not easy being green, Kermit, but I agree the pluses outweigh the minuses. **OSMA**

A. Robert Davies, MD, is in the Medical Division at Nationwide Insurance, Columbus, and serves on the OSMA's Committee on Communications.

GENERAL PHYSICIAN AND PSYCHIATRIC positions are available in Ohio, full- or part-time. Private practice opportunities are optional. Contact ANNASHAE CORPORATION, 6593 Wilson Mills Road, Mayfield Village, Ohio 44143 (216) 449-2662.

HOUSE PHYSICIANS: Full-time and part-time Medical/Surgical House Physicians positions available in July. Ohio license required. At least two years training in Internal Medicine or Family Medicine required. Prefer board eligible/board certified physicians. Hospital is a community teaching hospital. Attractive salary and benefits. Contact Barberton Citizens Hospital, c/o House Physician Recruitment, Tuscora Park, Barberton, Ohio 44203. Equal Opportunity Employer m/f/h.

HOUSE PHYSICIANS. Surgery and Medicine. Full-time and part-time. Send resume to: ST. JOHN AND ST. JOHN & WESTSHORE PROFESSIONAL CORPORATION, c/o 7911 Detroit Avenue, Cleveland, OH 44102, Attn: C.G. Cyrill, MD/Medical Director, Room 416.

INDIANA — 50 miles from downtown Chicago. Thirty-five physician multispecialty group located in northwest Indiana (pop. 60,000) is seeking second Orthopaedic Surgeon. With a service population over 110,000, this community is situated on the shores of Lake Michigan and offers exceptional recreational activities. The Clinic houses its own X-ray laboratory, audiology, physical therapy, surgery and ER. Excellent compensation and benefit package. Call or write Jean Ecos, 250 Regency Court, Waukesha, WI, 53186, 1-800-338-7107 or 1-414-785-6500 (Collect).

INDIVIDUAL/GROUP PRACTICE. Ohio, Cleveland. Established group has immediate openings for emergency residency trainee and/or Board Certified/prepared physicians. Competitive compensation, malpractice and flexible scheduling. Practice involves full trauma service, active EMS and teaching. Contact Rick Frires, MD FACEP (216) 761-4242 or send resume to 13951 Terrace Road, Cleveland, Ohio 44112.

INTERNIST — to join two established internists in large primary care practice

in Northeast Ohio. Salary and benefits first year and full corporate benefits thereafter. Physician-owned office contains complete service laboratory. Reply to Elyria Medical Group, 905 E. Broad St., Elyria, Ohio 44035.

INTERNAL MEDICINE — Board Certified/Board Eligible Internist is needed to join a six-man multispecialty internal medicine group practice in eastern Ohio. Position is available now. Excellent salary, benefits package and call coverage. This is an "instant practice situation" brought about by an increase in patient population. Send CV to: Dr. James V. Current, Medical Group Associates, Inc., 114 Brady Circle, East, Steubenville, OH 43952-1469.

INTERNIST NEEDED: An immediate opening exists for an internist or family practitioner, preferably board eligible or certified, in a rural, mountainous area of north central West Virginia with a newly renovated 26-bed hospital located in the town. Nestled in the heart of vacation and recreation areas, there is hunting, fishing, a championship golf course and two major ski areas located within an hour's driving time of the town. This practice has great potential with a lucrative guarantee and office space and support personnel provided the first year. In addition, a 146-bed hospital with all major specialties is located within 25 minutes of the practice. Contact or send your CV with home and office phone numbers to Robert L. Morris, CEO, Tucker County Hospital, Inc., PO Box 280, Parsons, W. Va. 26280-0280. EEO.

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NEUROLOGY — Immediate opening for board-eligible neurologist. West Central Ohio multi-hospital system. Excellent salary/guarantee plus fringes. PO Box 631, Vandalia, OH 45377-0631.

OBSTETRICIAN/GYNECOLOGIST — West Central Ohio multi-hospital system has several openings for board-eligible OB/GYN physicians. Excellent salary/guarantee plus fringes. PO Box 631, Vandalia, OH 45377-0631.

OHIO: Emergency Medicine positions ranging from part-time placements to full-time directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insurance. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

ONCOLOGIST

An established and progressive five-physician internal medicine group with emphasis on subspecialty practices is seeking an associate who is BC/BE in medical oncology.

Located in Fort Myers, Florida, a growing regional center for health care. This area has been attracting young professionals for over 10 years. The community has immediate access to sophisticated services in many fields and offers close affiliation with comprehensive clinical cancer activities. Send CV to: Sergio Mather, MD, c/o Internal Medicine Associates, 3800 Evans Ave., Fort Myers, FL 33901.

Interested persons may also contact Dr. Mather at (813) 936-1343 or Diane Barnes at (813) 433-5006.

ORTHOPEDICS — Immediate opening for certified or Board-eligible Orthopedic Surgeon in established practice with possible partnership. Affiliated with excellent hospital facilities. Salary negotiable plus fringe benefits. Send CV to PO Box 4375 Warren, OH 44481, or call collect at (216) 399-1864.

ORTHOPOD — Immediate opening for board-eligible orthopedic physician in established practice with possible partnership. Affiliated with Central Ohio multi-hospital system. Excellent salary/guarantee plus fringes. PO Box 631, Vandalia, OH 45377-0631.

PEDIATRICIAN — Immediate opening for board-eligible pediatric physician in established practice with possible partnership. Affiliated with West Central Ohio multi-hospital system. Excellent salary/guarantee plus fringes. PO Box 631, Vandalia, OH 45377-0631.

PHYSICIAN-HEALTH SERVICES THE OHIO STATE UNIVERSITY

The University Health Service at The Ohio State University is seeking a Physician to examine, diagnose and treat physical and health problems of student patients in the area of dermatology. This individual will perform surgical procedures, supervise and instruct students/residents, participate in clinical research programs and chair or participate on com-

mittees.

Candidates must have doctor of medicine degree, license to practice medicine in Ohio, and be board certified or eligible in dermatology. Salary is negotiable. To assure consideration, materials must be received by April 1, 1988. Apply to D.I. Charles, MD, Director, The Ohio State University Health Service, 1875 Millikin Road, Columbus, OH 43210. An Equal Opportunity, Affirmative Action Employer. Minority candidates and women are encouraged to apply.

PLASTIC AND RECONSTRUCTIVE SURGERY. Excellent opportunity available to Board Certified physician in our beautiful community. Sandusky's hospitals are interested in learning more about you. Send CV to Firelands Community Hospital, Ron Parthemore, 1101 Decatur Street, or to Providence Hospital, Bill Gallagher, 1902 Hayes Avenue, Sandusky, Ohio 44870.



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A leader in clinical research for the pharmaceutical industry seeks a Medical Director for expanding research operations. Experience in Phase I and II research in the pharmaceutical industry and Ohio medical license, or eligibility for same, are essential.

Please forward resume in confidence to J. James Pearce, Jr., President, Hill Top Pharmatest, Inc., P.O. Box 429501, Cincinnati, OH 45242.

PLASTIC SURGEON — Immediate opening for board-eligible plastic surgeon. West Central Ohio multi-hospital system. Excellent salary/guarantee plus fringes. PO Box 631, Vandalia, OH 45377-0631.

PRIMARY CARE PHYSICIAN and general staff psychiatric positions available. Some directorships also available. Excellent opportunities. Reply to: Peggie Roberts, Annashae Corp., 6593 Wilson Mills Road, Mayfield Village, OH 44143, (216) 449-2662.

PSYCHIATRIC PHYSICIAN

Immediate openings for Psychiatric Physicians, full and part time, in a state operated, JCAH accredited, 380-bed, inpatient psychiatric hospital. Duties include: plans medical and psychiatric treatment of mentally ill patients, administers psychotherapy and other treatment procedures, and acts as Treatment Team Leader. Must have 2 years psychiatric residency training and full/limited State of Ohio license to practice medicine.

Peaceful environment on a spacious campus with rural atmosphere. Located within commuting distance of a metropolitan area with easy access to major cultural centers. Wage starts at \$46,904 annually with provisions for increase. Excellent benefits including: Public Employees' Retirement System, Deferred Compensation Plan, health care benefits, paid vacation, personal leave and life insurance. EEO Employer, M/F/H.

Send resume to W.J. Roberts, Director of Human Resources Dept., or Dr. Nathanael Sidharta, Medical Director, Massillon State Hospital, Box 540, Massillon, OH 44648, or call (216) 833-3135, ext. 228 or 229.

PSYCHIATRISTS — FULL/PART-TIME.

Immediate openings for Board Certified/Board Eligible Psychiatrists, to join our multi-disciplinary treatment staff. We are a progressive, JCAH-accredited, 430-bed psychiatric hospital. Full-time starting at \$65,374 with an excellent benefit and retirement package. Toledo Mental Health Center is located in Toledo, Ohio, offering numerous cultural and recreational opportunities. Please send CV in confidence to: Toledo Mental Health Center, Caller #10002, Toledo, Ohio 43699-0002. EOE.

RADIOLOGIST. Our 13-physician radiology group has an immediate posi-

tion for a Board Certified radiologist with subspecialty training and interest in ultrasound, at Akron General Medical Center. Contact: Richard Skoblar, MD, 216-384-6450; AGMC, 400 Wabash Ave., Akron, Ohio 44307.

RHEUMATOLOGY — Immediate opening for board-eligible rheumatologist. West Central Ohio multi-hospital system. Excellent salary/guarantee plus fringes. PO Box 631, Vandalia, OH 45377-0631.

595 IM Rural southern Ohio community seeks additional BE/BC internist to either join existing group or establish independent practice. Affiliation with full service med/surg hospital with wide variety of programs and services. Excellent outdoor recreational opportunities offered. Easy access to Cincinnati. Contact Kevin Duffy, VHA Physician Placement Services, 1600 Embassy Square, Suite 1605, Louisville, KY 40299, (800) 626-1857.

TALENT & DEDICATION SHOULD BE REWARDED

— Join TSG as a full-time or part-time emergency physician. With 10 years experience, TSG offers the expertise you need to plan your future. Career stability, flexible hours, highest rate paid, full liability coverage, incentive programs, many locations. Send us your resume or call today: 9 am-9 pm, seven days a week. TRAUMA SERVICE GROUP, PC Suite 114, Scott Plaza Two, Philadelphia, PA 19113, (215) 521-5100. Outside PA: (800) TRAUMA-6.

607 IM 200-bed teaching hospital in metropolitan Cleveland seeks additional internists to join practices of retiring physicians or set up solo practices. 95% of medical staff is BC and many have faculty appointments. This is a well-known hospital featuring state-of-the-art equipment. Contact Kevin Duffy, VHA Physician Placement Services, 1600 Embassy Square, Suite 1605, Louisville, KY 40299, (800) 626-1857.

UROLOGIST — One hour from Chicago's Loop. Progressive 35-physician multispecialty group in northern Indiana (pop. 60,000) seeking energetic, highly skilled urologist. Unlimited recreational and cultural opportunities. Guarantee and excellent benefit package. Call or write George Ivekich, 250 Regency Court,

Waukesha, WI 53186, 1-800-338-7107 or 1-414-785-6500 (Collect). No costs or obligations involved.

WANTED: THREE COOPERATING FAMILY PRACTITIONERS INTERESTED IN LIMITED OBSTETRICS.

Give up the Urban Rat Race. Come to lovely southern Ohio where your children can grow in safe surroundings and quality schools. Guarantee of \$75,000 income and furnished office. Only one hour from the state capital. Submit training and experience to: Secretary, Board of Trustees, Pike Community Hospital, 100 Dawn Lane, Waverly, OH 45690.

WELL-ESTABLISHED DERMATOLOGY PRACTICE FOR SALE:

North Central Ohio midway between Cleveland-Columbus. Good schools, cultural attractions, OSU branch. Should gross over \$200,000. Office and two rental condos available. Terms negotiable. Flexible financing. Owner retiring. Send reply to PO Box 161, c/o OHIO Medicine, 600 S. High Street, Columbus, OH 43215.

668 IM Well-respected internal medicine group in West Central Ohio seeks additional general internist. All members are young, BC, and have teaching appointments at nearby university. University-trained candidates preferred. A subspecialist willing to devote the majority of his/her time to general internal medicine could be considered. Attractive office space located near progressive 125-bed hospital with easy access to Dayton. Numerous recreational, cultural and educational opportunities available. Contact Kevin Duffy, VHA Physician Placement Services, 1600 Embassy Square, Suite 1605, Louisville, KY 40299, (800) 626-1857.

Equipment for Sale

FOR SALE: Refurbished medical equipment. Exam or lights. Autoclaves, anesthetic machines, specialty equipment. Call or write Dr. Byron Bernard, 1555 Dixie Highway, Park Hills, KY (606) 581-5205.

Miscellaneous

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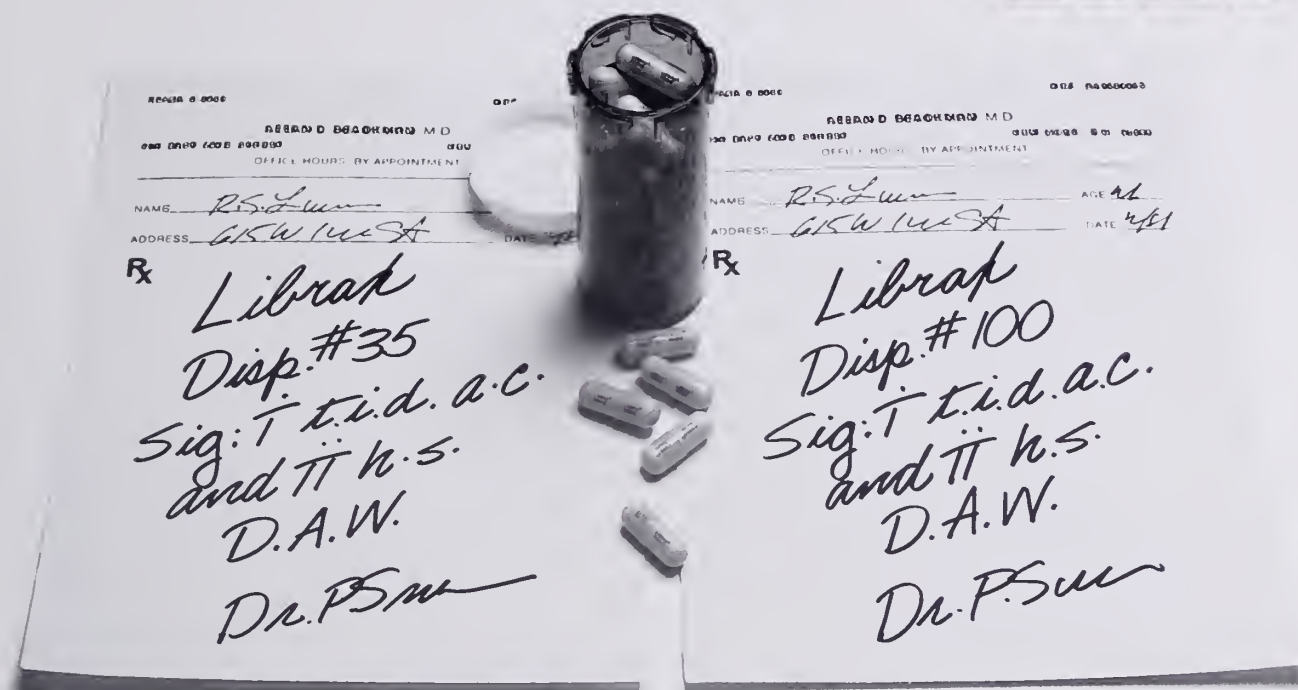
President's Page . . . continued

As chilling as the results of this study are, we must not lose hope. A more detailed description of the results of the survey — and recommendations on steps the OSMA can take to help resolve the problems — will be included in a future issue. The OSMA is committed to resolving this issue. But the solutions lie with us as individuals as well. Let Ohio physicians, utilizing information and knowledge provided by the OSMA, heed the soothsayer and "Beware the Ides of March," lest we, through competitive deals either for that extra patient or that extra dollar, become a case of "et tu, Brute."

By regarding ourselves with such knowledge and by working within our profession and our association we can and will win the battle of liberty versus tyranny. Those historical lessons remembered from 44 B.C. would do much to keep Ohio medicine IN CHARGE in '88. OSMA

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

“Possibly” effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

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*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and the irritable bowel syndrome.

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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 84, NO. 4

APRIL 1988

**TAKING
CHARGE**

1988 Annual Meeting

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Please see references and summary of product information on following page.

References: 1. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 31:355-361, Mar 1977. 2. Kales JD, et al. *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 3. Kales A, et al. *Clin Pharmacol Ther* 18:356-363, Sep 1975. 4. Kales A, et al. *Clin Pharmacol Ther* 19:576-583, May 1976. 5. Kales A, et al. *Clin Pharmacol Ther* 32:781-788, Dec 1982. 6. Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc* 27:541-546, Dec 1979. 7. Dement WC, et al. *Behav Med* 5:25-31, Oct 1978. 8. Kales A, Kales JD. *J Clin Psychopharmacol* 3:140-150, Apr 1983. 9. Tennant FS, et al. Symposium in the treatment of sleep disorders; teleconference, Oct 16, 1984.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precaution: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function. Inform patients to consult physician before increasing dose or abruptly discontinuing flurazepam HCl.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, tinnitus, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Dosage: Individualize for a maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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FROM THE EDITOR

Taking Charge

Over the past year, OSMA President D. Ross Irons, MD, has stressed his simple, straightforward message time and time again . . . "Take charge," he encourages members, urging them, as much by action as by word, to take a proactive stance in their profession whenever possible.

No wonder, then, that the OSMA Committee which selects the theme for each year's Annual Meeting grabbed at the powerful phrase and designated it as this year's theme.

Certainly one way that you *can* "Take Charge," and take a proactive stance in this association is to attend the Annual Meeting, to be held in Cincinnati the weekend of May 20-22. The annual business meeting of the OSMA allows you to raise or react to issues and concerns which merit the attention of the profession as a whole. Are you unhappy with the control government seems to be gaining over your practice? Are you dissatisfied with the policies of third-party payers? Then *now* is the time to take charge of what is happening to medicine. Come to Annual Meeting and let your voice be heard.

In this issue of *OHIO Medicine*, you'll find all you'll need to know about this year's meeting . . . who is running for office . . . who your delegates are . . . the format and schedule . . . as well as some of the resolutions which will be introduced before the House. Hold onto this issue, and circle the dates of this year's meeting on your calendar, THEN MAKE

PLANS TO GO! (We've included a hotel reservation form for your convenience.) Medicine cannot take a proactive stance — or any stance for that matter — without your help. Come participate.

Also in this issue, we continue our ethical look at reproduction technology which we began last month. Dr. Stanley Troup of Cincinnati presents a thought-provoking medical view of the subject, while Dr. John Sanders of Cleveland presents an obstetrician's view.

And Dr. Ted Castele, new chairman of the Ohio delegation to the AMA has outlined for you all the reasons you *should* belong to the AMA — and what happens if you don't. You'll find it on our "Focus on Membership" page. Read it . . . if you're not already an AMA member, you're sure to become one.

Finally, be sure to read this month's "Out of Practice" column. It features Springfield physician Carlos Andarsio, MD, and his monthlong study of the AIDS virus at a seminar in San Francisco.

Speaking of AIDS . . . that subject will, once again, be the focus of our attention next month. There are still areas of that subject that need to be brought to attention . . . and areas that need updating. Next month, we'll attempt to do both. Don't miss it! OSMA

Karim S. Edwards

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OUR COVER

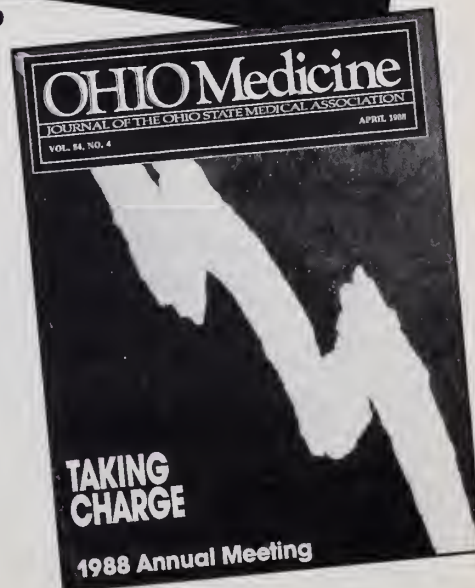
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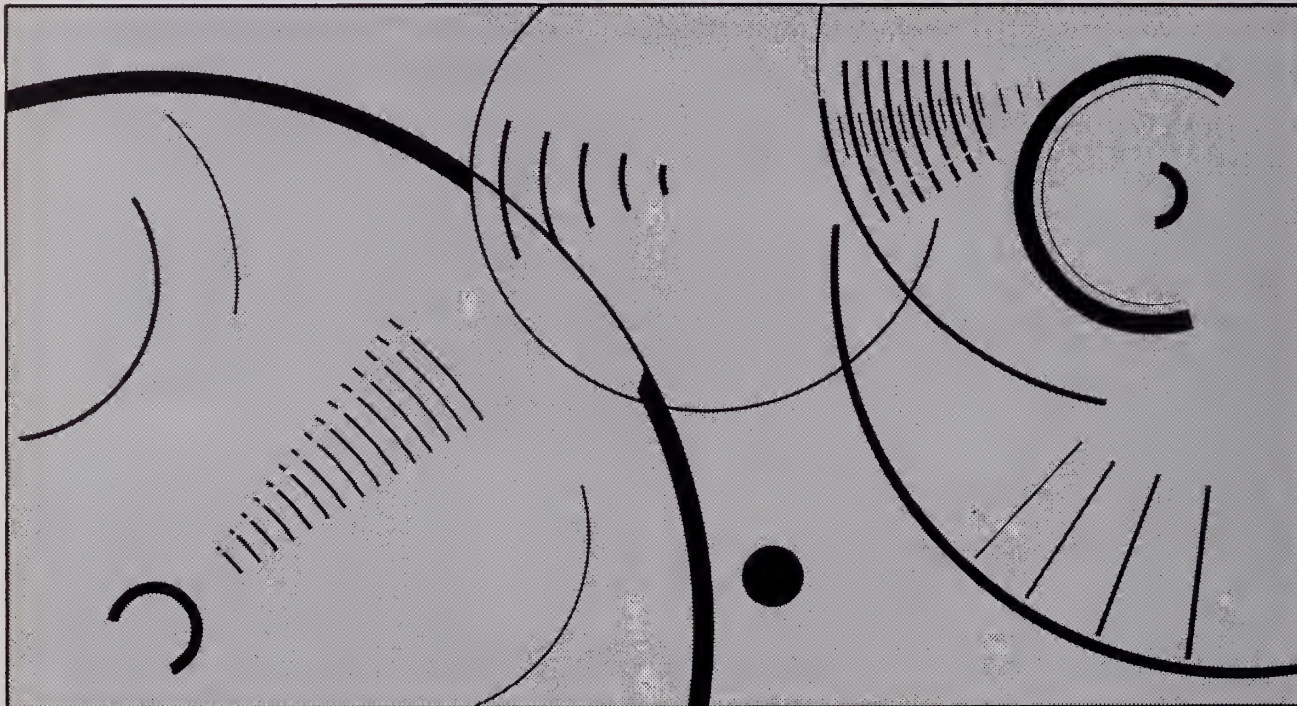
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PROGRESSIVE APPROACHES TO BREAST CANCER: A SYMPOSIUM



Parma Community General Hospital and Case Western Reserve University School of Medicine present a symposium on Breast Cancer for Physicians, Registered Nurses, and related medical professionals.

- Nationally Recognized Physicians
- Panel Discussion with General Practice, Internal Medicine, OB / GYN, and Radiology Physicians
- Clinical Examples and Case Studies in Breast Cancer
- Management Issues from all Perspectives
- Patient Options in Reconstruction Surgery
- Role and Relationship of all Specialists

**Parma
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General Hospital**

Saturday, May 7, 1988

8:00 a.m. — 3:00 p.m.

Marriott Hotel (West), Cleveland, Ohio

Accredited for 5 hours of Category 1 of Physician Recognition Award of the AMA and OSMA by Parma Community General Hospital.

For further information, call Kathleen Blake, Continuing Medical Education Coordinator, Parma Community General Hospital, at (216) 888-1800 extension 3442.



Why a dues increase?

By D. Ross Irons, MD

April Fools' Day will have come and gone by the time you read this President's Page, but the joke's on all of us if we think the OSMA can continue to effectively operate at the current dues rate.

The challenges facing medicine have become more complex each year. And the OSMA, as the organization which represents more than 20,000 of Ohio's physicians, residents and medical students, has always strived to stay on top of these changes — protecting your rights and the rights of your patients.

But, plain and simple, the cost of operating the association has risen tremendously. Expenses have increased an average of 7 percent a year for the past few years while income has only increased by an average of 3 percent a year during the same period. Adequate revenues must be maintained in order for the OSMA to continue to meet the challenges and problems faced by physicians today, as well as those that will affect organized medicine in the future.

As a result, the Council of the OSMA has submitted a resolution for consideration at the 1988 annual meeting of the House of Delegates which asks for an

increase in association membership dues. The proposed increase would take effect over a three-year period — \$60 in 1989; \$30 in 1990; and \$30 in 1991.

This recommendation was not made lightly. The leadership of the OSMA has been doing everything possible to keep the association's expenditures in check. The validity of every service and activity, whether it has been around for years or if it has been newly initiated, is measured to assure that it is the most cost-effective means of meeting members' needs. And, although the number of services available to members has grown since the last dues increase in 1984, the number of staff employees at the association has actually decreased. The OSMA has the lowest staff-to-member ratio among the country's top state associations.

Furthermore, as far as the dues rate is concerned, the OSMA ranks seventh among the top 10 associations in dues rate, yet it ranks fourth according to total membership.

The OSMA House of Delegates last approved a dues increase in 1984. At that time projections indicated that the increase would sustain the operation of the association for three years with a

need for an increase projected for 1987. However, with careful planning and budgetary restraints, association leadership was able to sustain the organization with current dues-level income and avoid an increase for an additional year.

The dues increase you will be asked to consider at the 1988 Annual Meeting will allow the OSMA to **maintain** its current level of services to members. In order to assure the availability of funding for **new** programs and activities, the OSMA will continue to monitor the need and effectiveness of ongoing activities, making cuts when needed. This helps to ensure that new programs and activities can be initiated with limited need for increased revenues.

In the years to come, the OSMA will continue its efforts to hold down costs by seeing that all programs are operated in the most cost-effective manner and by making conservative budgetary decisions. The association also will continue to seek the best sources for non-dues revenue in order to keep dues at the lowest possible rates.

But as we try to hold down costs, the number of challenges that face organized medicine will

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continue to grow. The state and federal legislatures, private and public third-party payors, the medical board, alternative delivery systems, rule-making bodies and the media all present challenges which require creative solutions. Overcoming these challenges and meeting the growing needs of every member of the OSMA will require your support, perseverance and adequate financial resources.

April Fools' Day to the contrary, this is no joking matter. None of us should be caught believing that our association can continue to represent us and adequately serve our needs without proper financial support.

Medicine needs your help in order to be IN CHARGE in 1988.

Cincinnati to Host OSMA Auxiliary

The 1988 OSMA Auxiliary Convention will be held May 19th and 20th at the Terrace Hilton Hotel in downtown Cincinnati. Leadership Day will occur May 18th.

Registration will take place Thursday morning, May 19th, prior to our Continental breakfast. (Juices, breads, pastries and beverages — breakfast will be available with your luncheon ticket both days.)

As the business session on Thursday ends, a tasty luncheon will be awaiting you. After lunch, a lovely Tour of Cincinnati and Northern Kentucky (that will include a stop at Eden Park's Krohn Conservatory and historical Riverfront) or an afternoon of browsing and shopping in

downtown Cincinnati has been planned.

A cocktail party for our State President, Joyce Johnson, will be hosted by Franklin County on Thursday evening. Immediately following, a gourmet prime rib dinner will be served. "Teenagers," a choral group from Colerain High School, will present a show for our entertainment. We'll "Tune in and Take Note."

After Friday morning's Continental breakfast and business session, Clark County will host a reception for President-Elect Catherine Staton. Lunch on Friday will include the formal installation ceremonies for the OSMA Auxiliary officers for 1988-1989. Won't you join us?

A WORD TO THE WHYS

WHY AMA?

The AMA has tackled the issue of cost effective quality medical care by supporting the development of health care coalitions. The Association believes the best mechanism for keeping health costs down without sacrificing quality or accessibility is through voluntary coalitions in which physicians actively participate. Working to promote high quality, affordable medical care in the United States: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

WHY AMA? Through the AMA library you can have immediate access to a vast store of medical, scientific, and socio-economic information. The library maintains a large collection of books, journals, and micro-film and provides instant on-line access to countless information sources through computerized data bases. The AMA library: it's one more good reason why you should be part of the AMA.



Preventable trauma deaths

To the Editor:

I read with great interest the article by Kudsk and Fardal, entitled, "Preventable Trauma Deaths," (*OHIO Medicine*, January 1988). One has to be impressed to know that, at long last, some effort is being made in our own state to develop a "statistical handle" on the morality and morbidity associated with injury and its management.

One would, undoubtedly, need far more factual detail in reference to the individual cases presented here in order to make an appropriate statistical judgment; nevertheless, let us recognize it for what it is: an honest attempt to define the causes, both preventable and non-preventable in traumatic death.

My major disappointment with this article is the authors' statement: "... salvageability of head-injured patients was difficult at best, and if they were included, the study's credibility might be impaired." The authors well know that the previous investigations of this kind have recognized the inclusion of head injury; for example, the surveys done in Orange County, California. As a consequence, I am of the opinion that their study is seriously flawed by eliminating this type of trauma.

Let us see more of these types of investigations in the metropolitan communities of Ohio, but let us not leave out head injuries in these types of epidemiologic studies.

Robert J. White, MD, PhD
Professor of Surgery, CWRU
Director of Neurosurgery,
CMGH
Director of Brain Research
Laboratories, CMGH
Cleveland

To the Editor:

In your recent journal, *OHIO Medicine*, there appeared an article by Kenneth A. Kudsk, MD, and Patrick M. Fardal, MD, concerning preventable trauma deaths.

As Trauma Director for St. Anthony Medical Center, I reviewed this article with great interest. The data gathered during 1983-84 is very difficult to extrapolate to the current situation in Ohio in 1988. You must be aware that Ohio State, Grant, Riverside, Mt. Carmel and St. Anthony's have all been verified as meeting the standards for a Level One Trauma Center by the American College of Surgeons after meeting very rigorous standards. I suspect that the number of preventable deaths has decreased by 90 percent or more since the original statistics were first gathered by Dr. Kudsk.

St. Anthony Medical Center receives a very high percentage of penetrating injuries and we are very dedicated to the pursuit of excellence in dealing with these trauma patients. The basic fact that the major hospitals in Columbus have geared up appropriately to deal with trauma means that any patient severely injured by any form of accident, either blunt or penetrating, will receive a very high level of care irrespective of what hospital the patient is taken to. I believe that this type of dedication which exists in Columbus makes a regional trauma center unnecessary.

The preventable trauma deaths occurred in a system that no longer exists in Columbus. Therefore, this article is basically one of an anecdotal historical statement and should be taken in

that light.

Thank you for your time and consideration.

Sincerely,
Richard E. Schlanger, MD, PhD
Director of Trauma Program
St. Anthony Medical Center
Columbus

Electroconvulsive therapy as a treatment of choice

To the Editor:

I read with interest the article in the December 1987 issue of *OHIO Medicine* on the clinical update on the woes of the elderly. The article did discuss elderly depression and was quite comprehensive, but I was struck by the glaring omission of the major effective treatment modality known as electroconvulsive therapy.

I'll give you a reference to support my contention that electroconvulsive therapy is the first treatment of choice in the depression of the elderly. In a recent issue of the Harvard Mental Health Letter, there is a quotation from the *Journal of Comprehensive Psychiatry*, Issue 28, pages 169-182, which compares electroconvulsive therapy versus drugs, and this was some work done at the University of Iowa. Also, I have attended psychopharmacology course seminars at Harvard and the consensus of several lectures is that it is much safer and more effective treatment of depression in the elderly than is the pharmacological treatment. In my own experience I find that the geriatric population is not very well able to tolerate most of the antidepressant medications and

continued on page 252

some are completely contraindicated on the basis of good medical judgment.

Post-stroke and post-myocardial infarction are frequently treated quite effectively with electroconvulsive treatment, and the incidence of depression in this group is fairly high.

I feel that the general physician population should be more aware of this treatment modality and its relative safety over other treatment methods.

L.E. Whitmire, MD
Toledo

HEALTHCHEK exams

To the Editor:

Thank you for publishing the article entitled "HEALTHCHEK: A New Name for an Enduring Program," which appeared in the December issue of *OHIO Medicine*. The Bureau of Medicaid Preventive Health welcomes any opportunity to provide information to medical providers across the state and to increase professional participation in the HEALTHCHEK program.

Please note, however, the following correction regarding the allowable number of examinations. In your article, you stated that six exams are provided in the first year of the child's life. The correct information is that a total of *eight* HEALTHCHEK examinations may be administered to Medicaid-eligible children *between birth and age two*. Following his or her second birthday, each child may receive one examination per calendar year. This new exam schedule has been in effect since the revised HEALTHCHEK medical rules were issued on September 1, 1987.

Should you have any inquiries regarding participation in the HEALTHCHEK program, please direct interested parties to the

Bureau of Medicaid Preventive Health. The telephone number is (614) 466-4966.

Again, thank you for your interest and assistance in promoting the HEALTHCHEK program.

Sincerely,
Morris S. Dixon, Jr., MD
Medical Technical Adviser
Bureau of Medicaid Preventive Health
Columbus

Student appreciation

To the Editor:

I'm a first-year student at Wright State University and just today received the February issue

of *OHIO Medicine* in my mailbox. I just wanted to drop a note to tell you how much I liked it.

We receive a number of publications as first-year students, but this is the first one that I've wanted to sit down and read.

Keep up the good work.

Sincerely,
James O. Doone, Jr.
Dayton

The OSMA Journal welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.

DOCTOR, is it time for a change?

- You're spending too much time on paperwork.
- You want to live in Europe, not just vacation there for a couple of weeks.
- You want to get involved with academic medicine, full-time.
- You want to subspecialize, but can't support your family on a fellow's stipend.

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CT as an Initial Screening Tool: A Step Back Into the Dark Ages?

By W.E. Feeman, Jr., MD

Editor's Note: The January issue of OHIO Medicine carried an article, "Waging a War Against Cholesterol" by Associate Editor Deborah Athy. The following article was received in response to that piece.

I am disappointed by the proposal of the National Cholesterol Panel that the total serum cholesterol (CT) be used as the initial screening tool to evaluate patients for the lipid portion of the risk factors that lead to atherosclerotic disease (ASD). CT is not the best lipid predictor — it was good in its day (prior to 1975), but that day is long gone and the continued use of CT as a screening tool represents a step backward into the "Dark Ages" of medicine. The unfortunate sequel of the panel's recommendation is that some physicians actually believe the panel and will stop looking at LDL and HDL cholesterol levels in patients whose CT is less than 200 mg/dl. And that will have tragic consequences when those who are missed by the CT screen develop their ASD.

The data I am about to present derives from the Bowling Green Study (BGS), as well as my

ongoing prospective and retrospective investigation into the primary and secondary prevention of ASD. Since the BGS is ongoing, the exact number of patients involved is always in flux, but as of this moment involves over 7,000 patients of all ages, a "slice of life" representing my private practice of family medicine in Bowling Green.

I stopped using CT to screen for anything except cord blood cholesterol in 1978 when HDL and hence LDL cholesterol testing became available in Bowling Green. I switched because although CT was a good predictor when CT is greater than 250 mg/dl, as CT fell away from the 250 mg/dl mark, CT became a progressively worse predictor. Analysis of the BGS data reveals the reason for this finding. When CT is greater than 250 mg/dl, LDL levels are virtually always above the LDL upper limit (in this study) of 170 mg/dl. As CT levels fall away from the 250 mg/dl mark, the number of patients with LDL levels exceeding the 170 mg/dl cutoff likewise falls away, such that when CT is less than 230 mg/dl, virtually no one has an LDL greater than 170 mg/dl.

These observations provide a

firm foundation for the caution against generalizing the Lipid Research Clinic's findings to the whole population.

Indeed, many people with CT less than 250 mg/dl have no lipid abnormalities whatsoever, or at worst only a mild elevation of the triglycerides, and such people are not candidates for intervention. Those people who do have lipid abnormalities should have the specific abnormalities remedied by specific therapies. Those people who do develop ASD in this lipid group usually do so on the basis of an HDL abnormality. Deficiencies of HDL are not detectable by the use of CT as a screening tool and are not treated by a low cholesterol diet, which can only further lower their already low HDL levels. Even so, physicians may ask how important this group of people is with respect to the overall goal of preventing ASD. To answer this question, I have broken down my male ASD patient data in terms of CT category and age group for ASD of the heart (ASHD), ASD of the brain (ASBD), and ASD of the peripheral arteries (ASVD).

From the following table, it can be seen that if one selects 250 mg/dl

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as the CT cutoff point, then 66% of ASHD, 65% of ASBD, and

the BGS, of the 683 women with CT less than 200 mg/dl, 98% were

follow-up testing.

Examining the entire BGS population, one notes that HDL abnormalities occur in 29% of men and in 15% of women whose CT's are less than 200 mg/dl. None of these people would have been detected if LDL and HDL determinations were limited to that portion of the population with CT less than 199 mg/dl. (The rate for men is 76/259 and for women is 47/318.)

Incidentally, what happens when TG is more than 500 mg/dl? the Frederickson formula is not valid at that level and LDL cannot be calculated. Moreover, since on any given sample of serum, different laboratories will give different values of LDL, isn't it unrealistic to say that we should shoot for a certain LDL level? Use of a ratio between LDL and HDL could eliminate laboratory technique bias.

2) *NCEP suggests that HDL is an independent risk factor.*

COMMENT: At any given level of HDL, the ASD risk of any given patient may not be the same as that of any other patient. The ASD risk at any given level of HDL is dependent primarily on the associated LDL level and the cigarette habit, and to a lesser extent on the systolic blood pressure (SBP). No one can assign an ASD risk value to any HDL level without knowing these data.

For this reason, the best lipid predictor is some measure of the LDL and HDL balance. I have suggested the cholesterol retention fraction (CRF) as the best measure of that balance, but others have used the LDL:HDL ratio. The CRF is defined as: $\frac{LDL-HDL}{HDL}$ and has the following advantages over the LDL:HDL ratio:

a) the CRF provides a cleaner concept. It gives the "best guess" of the percentage of the

CT CATEGORY	AGE GROUP				
	< 49	50-59	60-69	70-79	> 79
ASHD					
< 200	1	4	6	2	3
200-224	5	6	6	3	2
225-249	2	3	6	2	3
> 249	7	6	7	7	1
ASBD					
< 200	1	1	2	0	1
200-224	0	1	3	2	0
225-249	0	2	1	4	2
> 249	0	1	3	5	2
ASVD					
< 200	0	1	2	1	2
200-224	0	0	2	1	0
225-249	0	0	1	2	2
> 249	0	2	4	3	0

61% of ASVD patients will be missed. (I make this point for those who think that using a CT cutoff of 200 mg/dl — and therefore putting half the American population on a diet — is unwise.) Even if one uses a CT cutoff point of 200 mg/dl, one will still miss 20% of ASHD, 16% of ASBD, and 26% of ASVD patients. On the other hand, if one looks at HDL levels in all (ASD and non-ASD) patients with CT less than 200 mg/dl for whom HDL data is available, one finds that 76 of the 259 values are low. (The cutoff value for HDL in the BGS is 40 mg/dl.) This compromises 29% of men who would be missed if a CT screen were used.

The female ASD population is mainly characterized by elevated CT and LDL levels. Hence a CT cutoff of 250 mg/dl will miss 51% of ASHD, 35% of ASBD, and 57% of ASVD patients. A CT cutoff point of 200 mg/dl misses only 11% of ASHD and 10% of ASBD patients, but no ASVD patients. This sounds good, and in

free of ASD. Of the 683 CT's however, HDL data is available for 318 women, and of the 318 HDL's, 47 were low. This amounts to 15% of women whose low HDL's would not have been detected if only a CT screen had been used. Here are some further comments on specific NCEP points:

1) *NCEP recommends using CT as the screening tool*, examining LDL and HDL only if CT is greater than 199 mg/dl.

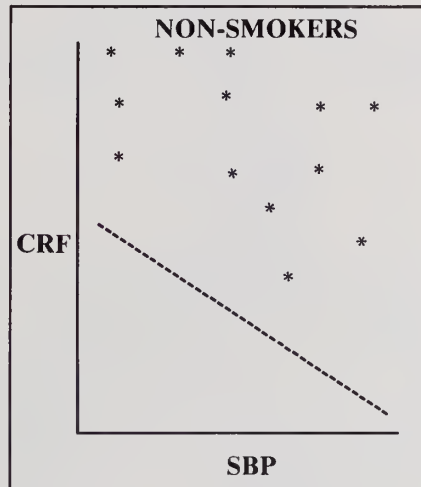
COMMENT: The use of CT as the initial screening tool will fail to detect lipid abnormalities in all patients with low HDL levels and CT less than 200 mg/dl. In the BGS, this constitutes about 20% of male ASD patients and about 10% of female ASD patients. Since LDL normally rises with age and since repeat screening is recommended every five years, these patients will eventually be detected, but in the meantime their ASD processes will continue to run unchecked. And there is always the possibility that the patients will not return for their

cholesterol entering the artery wall that remains there. Furthermore, it puts the emphasis on the LDL, which is a more important risk factor than is HDL. (Both the CRF and the ratio have an upper limit of LDL — in the BGS, 170 mg/dl — above which predictive ability is diminished. That is to say, when LDL exceeds 170 mg/dl, ASD will develop despite high levels of HDL. However, the higher the HDL, the later in life does ASD develop, such that a low CRF is predictive of late-onset ASD.)

b) The CRF is more accurate than the ratio. In the BGS, the CRF cutoff of 70% detected 3% more ASD patients than did the ratio cutoff of 3.5.

3) *The NCEP uses LDL as an independent risk factor.*

COMMENT: LDL is not an independent risk factor. Below levels of 170 mg/dl, the amount of LDL tolerable without developing clinical ASD depends directly upon HDL levels. Given two normotensive nonsmokers, both with LDL's of 120 mg/dl, and given one patient with an HDL of 25 mg/dl and the other patient with an HDL of 65 mg/dl, the former patient will develop ASD whereas the latter patient will not develop clinical ASD within the first eight decades of life. The best method of predicting who will and who will not develop clinical ASD within the first eight decades of life is to prepare a graph with the CRF on the ordinate (vertical line) and SBP on the abscissa (horizontal line) for never-smokers and a separate graph for ex-smokers — virtually all current-smokers will develop ASD within this time frame unless cancer or chronic lung disease strikes first. If the CRF-SBP plots of all ASD patients in the BGS are graphed, then a zone appears which



contains no ASD plots. No person whose plot remained in this "safe zone" throughout the study period developed clinical ASD. If LDL values are substituted for CRF values, then no such safe zone appears. It should be noted that the safe zone of never-smokers is larger than the corresponding zone for ex-smokers. There are now six studies that show angiographic stabilization and/or reversal of ASD plaques when LDL is lowered and HDL is raised. If only LDL is lowered, plaque stabilization may occur but plaque reversal is less likely.

4) *The NCEP suggests LDL and HDL determinations* for the CT range of 200-239 mg/dl only if two other risk factors are also present.

COMMENT: This recommendation minimizes the prime importance of LDL and HDL in the pathogenesis of ASD. People with isolated LDL and/or HDL abnormalities will develop clinical ASD regardless of the presence or absence of other ASD risk factors — it's just that when other risk factors are also present, clinical ASD develops at an earlier age than when they are not present. There is no reason to ignore the prime risk factors just

because lesser risk factors are not also present. However, the addition of qualifying regulations as to when to and when not to do LDL and HDL levels simply complicates matters. The graph developed by the BGS and described above eliminates these complications — to wit, if the patient is in the safe zone, no further action need be taken; if the patient is in the danger zone, then action must be taken to bring him/her back into the safe zone.

5) *The NCEP offers treatment goals only for LDL.*

COMMENT: LDL is not an independent risk factor. Below 170 mg/dl levels, the amount of LDL tolerated without producing clinical ASD depends directly upon the associated HDL level. Most workers in the field of the primary and secondary prevention of ASD consider HDL to extract cholesterol from the arterial wall and/or from the LDL lipoprotein itself. It is the entrance of cholesterol into and back out of the arterial wall that makes ASD plaques wax or wane, and it follows that knowledge of both LDL and HDL levels must be had in order to determine whether the plaque is waxing or waning. As I noted earlier, there are now six studies that have shown that the best plaque stabilization and/or remission occurs only when LDL levels fall and HDL levels rise. The rationale of what constitutes an adequate treatment goal is unclear to me. Why should there be a difference between ASD patients and non-ASD patients? Once the decision is made to treat blood cholesterol levels, why not get everyone's LDL and HDL levels down to the level where plaque reversal can occur? I therefore propose a two-step program. First, get everyone's

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LDL levels down to 170 mg/dl and raise HDL levels up to 40 mg/dl. Second, bring LDL levels down to the 120-130 mg/dl level and raise HDL levels up to 45-55 mg/dl range, such that the CRF is at or below 60%. The six studies previously described have shown plaque reversal when the CRF is at or below 60%.

6) *The NCEP recommends a "stepped care" approach to lipid therapy.*

COMMENT: Treatment should be tailored to the specific abnormality exhibited by the patient. Furthermore, the degree of LDL or HDL abnormality also requires consideration when the choice of a drug is being considered. Some drugs mainly lower LDL while others mainly raise HDL. Nicobid, for example, is a good drug and will lower LDL while raising HDL levels; however, it is not a strong drug and is better suited to milder LDL and HDL aberrations. Questran is an excellent drug for higher LDL elevations and has the added advantage of raising HDL levels, but its GI side effects render it unsuitable in older patients. (Here I have given one packette at bedtime with fair to good results on LDL levels, but without much in the way of GI side effects.) Lopid is good for raising HDL levels and at times will also lower LDL levels as well. Lorelco is good for higher LDL elevations, but has the disadvantage of lowering HDL levels, sometimes drastically. Mevacor, on the other hand, cannot only bring down high levels of LDL, but will also raise HDL. If only perimenopausal and post-menopausal women are considered, hormone replacement therapy can be quite useful in the management of menopausal hyperlipidemia. In short, I suggest that the treating physician consider the nature of the lipid disorder being treated, as

well as its severity, when deciding which medication to use.

The point of this article is to register a plea to the physicians of America, indeed the physicians of the world. Do not look only at CT — that would be a backward step in medicine. In my opinion, the best lipid predictor is the Cholesterol Retention Fraction (CRF): $\frac{\text{LDL-HDL}}{\text{HDL}}$

This is the screening tool I suggest be used. But whether you use the CRF or the slightly less accurate LDL:HDL ratio, do not stop using some measure of the LDL and HDL balance as your lipid screening tool.

W.E. Feeman, Jr., MD, is a general practitioner in Bowling Green, Ohio. This material has been presented by Dr. Feeman at numerous medical and scientific meetings, and has been published in The Medical Tribune as well as the Family Physician News.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine or the Ohio State Medical Association.

Quotes of Note

"The secret of my success is that at an early age I discovered I was not God."

— Oliver Wendell Holmes, Jr.

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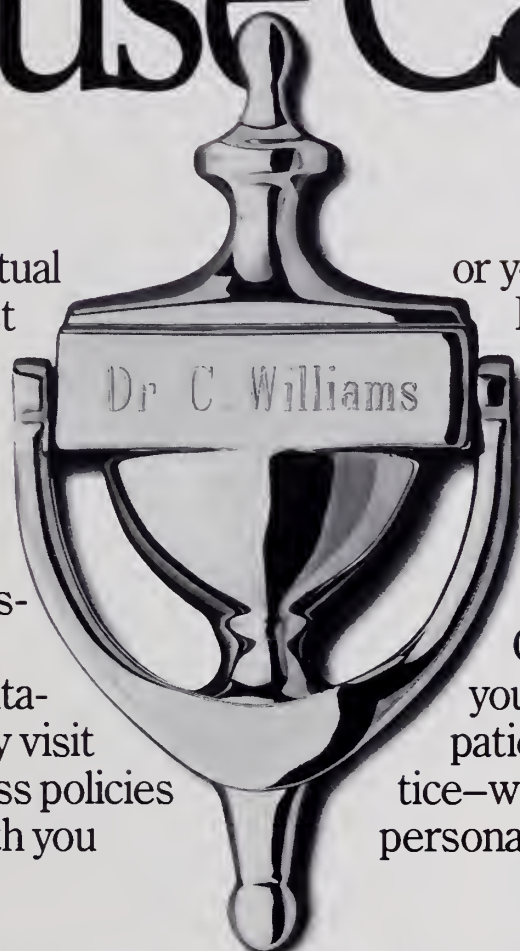
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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

Medicine's expanding arsenal...

high tech on the horizon

Bandages that don't just protect a wound but actually help it to heal... an implantable drug delivery device which ensures a patient consistent doses of medicine. These futuristic-sounding medical advances may be only five to 10 years away, says a report recently issued by Arthur D. Little, Inc. of Cambridge, Massachusetts, a technology and management consulting firm.

According to the report, biological and synthetic materials that actively promote healing are taking over the function of cotton gauze wound dressing. Modern thin films, backed with adhesive or sprayed on, have a controlled permeability to water and oxygen, adhere well to the area around a wound and enhance healing. They also provide a barrier to bacteria and prevent the wound from drying, a major advance over traditional gauze and nonadherent gauze dressings, the report says. The bandages are mostly used for intravenous sites, decubitus ulcers, minor burns and skin graft donor sites, but are not indicated for full skin-thickness wounds. Gels and colloids, which can be molded to the contours of a wound surface, have been particularly well received in the treatment of decubitus ulcers, while biologic dressings have been especially useful in treating severely burned patients.



Also rising quickly on the medical horizon are drug delivery devices that are implanted into the body, and are to be used in place of pills and injections for administering such medication as diabetic insulin, chronic pain medication, growth hormones, cancer medications, narcotic antagonists for the treatment of drug addicts, medication for mental illness as well as treatment for other chronic illnesses.

The report predicts that, within the next 10 years, several types of implantable devices will appear commercially, each with specific application. Some will be surgically implanted under the skin for prolonged drug release; other short-term therapy devices, formulated from microparticles or microcapsules, will be injected under the skin without an incision. Non-degradable devices will require removal, while biodegradable systems will erode concurrent with drug release or after release is complete.

Some systems are now in clinical trials and commercialization, based on FDA approval, is likely to occur within the next three years. However, bioresponsive systems will require eight to 10 years of development and testing before these devices will be commercialized, the report forecasts.

Routine use of bone-mineral densitometry not recommended

The routine use of bone-mineral densitometry in screening women for osteoporosis is not recommended, says the American College of Physicians, which believes that, while bone-mineral densitometry is a valuable research tool, it has not proven accurate in predicting future bone-mineral loss or fractures.

ACP found periodic use of bone-mineral densitometry was appropriate for monitoring patients receiving certain costly or potentially toxic treatments that could produce large changes in spinal bone-mineral content. However, periodic measurements were not determined to be sufficiently precise for monitoring less severe, short-term bone loss in either untreated persons or women taking estrogen or calcium to prevent osteoporosis.

According to ACP, few prospective studies have been completed on densitometry's ability to predict specific types of fractures, and retrospective case-control studies have been inconclusive. The most common densitometry methods vary in accuracy, cost and radiation exposure — all factors in determining whether their use is justified in screening patients.

If prospective studies establish that densitometry can predict fractures, then screening may become useful for some post-menopausal women deciding whether to begin estrogen-replacement therapy, added ACP.

The trauma of youth-sport injuries

Team physicians should be aware that the thousands of youngsters competing in school football activities or in similarly vigorous contact sports are unwitting candidates of traumatic arthritis, a form of osteoarthritis in which joint tissues break down.

Without top-notch early care, the condition can become chronic — especially if reinjury to the damaged joint occurs, says Marvin Thomas, MD, Chairman of the Medical and Scientific Committee for the Central Ohio Chapter of the Arthritis Foundation.

Although most youngsters have sophisticated equipment to protect them, as well as capable team physicians who watch for and treat injuries immediately, there are many who don't.

The medical community, parents and young athletes should all become aware of the potential seriousness of sports injuries and be sure they are treated appropriately to prevent long-term complications. Special precautions should also be taken to protect previously damaged joints from reinjury.



Risk of heterosexual HIV transmission varies

The number of times one has sexual relations with a person infected with the human immunodeficiency virus (HIV) does not determine one's risk of contracting the deadly AIDS virus, according to a study recently published in the *Journal of the American Medical Association*.

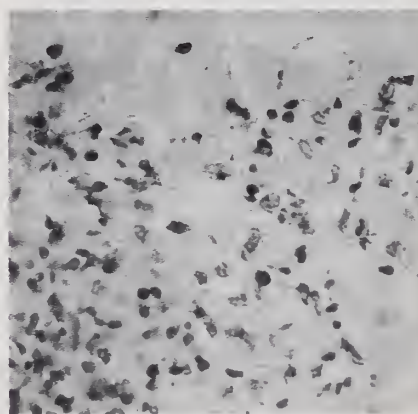
According to the report, some persons in the study became infected with HIV after only a few sexual contacts while others remained seronegative after hundreds of contacts.

The authors of the study, Thomas A. Peterman, MD, of the National Institute for Allergy and Infectious Diseases, and colleagues at the Centers for Disease Control and the New York City Health Department, studied families of patients who became infected by

HIV through blood transfusions in order to determine the risk of HIV transmission by female-to-male and male-to-female sexual contact, and by non-sexual contact among family members.

The study, which identified 106 families, found that in 80 families, spouses reported having had sexual contact with the infected family members, while 26 reported they had abstained from sexual contact since their spouses became infected. Two of the husbands and 10 of the wives of the HIV patients eventually tested positive for the virus.

While one of the seropositive women reported only a single sexual contact with her infected husband and another woman only eight such contacts, 11 wives remained uninfected after more



than 200 sexual encounters with their infected spouses, leading the researchers to conclude that heterosexual transmission of HIV is not simply a function of the number of sexual contacts with an infected person. Unfortunately, they add, the biological factors responsible for the variation in transmission remain undetermined.

Should children testify in sexual abuse cases?

Participating in a trial is likely to be traumatic for young victims of sexual abuse, says Alayne Yates, MD, in a recent issue of the *American Journal of Psychiatry*. Nevertheless, because the sixth amendment to the Constitution says the accused has a right to be confronted by the accuser — adult or child — prosecution may be impossible if children do not testify in such cases.

However, two factors need to be considered in determining whether children, age 3 years to 7 years, should be allowed to testify, says Dr. Yates. First, does the child have sufficient skill (competency) and memory (recall) to testify accurately; and second, will a child, who is already a victim, be further victimized by cross-examination, hours of interrogation and the stress of a direct confrontation with the accused?

Generally, it is up to the judge to determine the child's competency before the trial begins. The judge must consider whether the child can distinguish truth from falsehood, whether the child appreciates the need to tell the truth and whether the child's cognitive capacity is adequate. This sort of determination is difficult, particularly with very young children.

Attorneys and judges are also concerned about the consistency and validity of young children's testimony. According to Dr. Yates, some children are particularly suggestible when being asked leading questions by an authoritative adult. Others are easily intimidated or try too hard to please adults, while still others have very short attention spans.

Dr. Yates notes that no studies have been published about the extent to which children are helped or harmed by testifying but in his

experience, either outcome is possible, he says. Having the court "confirm" that the child was correct is frequently helpful, but the horror of reliving events through testimony is often harmful.

However, there are ways to reduce the trauma for the child, Dr. Yates continues. One is to examine the child in a separate chamber with the judge and the opposing counsel, while the accused views the proceedings on a video monitor or through a one-way screen (as is currently being done in Colorado). Another is to have the judge play a greater role in seeing that the child is as comfortable as possible, including calling a psychiatrist to advise the court on these matters.

In the spring of 1986, the American Academy of Child Psychiatry's council adopted a policy statement of recommended procedural modifications to protect children who testify.

Dr. Yates concludes that if child witnesses are to be humanely treated and protected from further



damage, greater involvement of child psychiatrists is clearly indicated.

Failure to diagnose cases

Allegations of failure to diagnose account for some 50% of malpractice claims against family physicians, a spokesperson for the American Academy of Family Physicians' task force on professional liability reported in *Medical World News*.

The three major areas of diagnostic failure are cancer, abdominal conditions, and fractures, with breast cancer being most responsible for legal suits against physicians.

"The single biggest mistake in this country in the early diagnosis of breast cancer is accepting a negative mammogram as evidence

that cancer is not present, especially when a palpable mass is there," said the academy's past chairman Holger Rasmussen, MD.

Suggestions in the article for minimizing the chance of legal action include good follow-up, continuity of care, good communication with patients and colleagues, involving patients in the decision-making, and keeping good medical records.

For more information, a medical liability report prepared by the American College of Physicians is available by writing: American College of Physicians, Department of Public Policy, 655 15th Street, Suite 425, Washington, DC 20005.

Physicians, medical students need more education on the drugs they prescribe

Physicians and medical students need better education in selecting and administering medication, according to the American College of Physicians (ACP), the nation's largest medical specialty society.

Physicians should also improve communication with patients about medications, and re-evaluate the pharmaceutical industry's role in providing drug information, continues the ACP in a position statement published in a recent issue of *Annals of Internal Medicine*.

Physicians' knowledge of drug therapeutics has not kept pace with advances in diagnosis. The amount of medication prescribed by U.S. doctors has increased dramatically in recent decades as new drugs have become available, and more medication is given per patient in this country than in many others. However, studies show that a significant number of U.S. prescriptions either specify inappropriate doses or are

unnneeded, notes the College.

The timing of pharmacology courses in medical school curriculums is one cause of this problem. Second-year students — with little or no hospital experience — study drugs “used to treat diseases with which they have only passing acquaintance,” according to ACP. Some medical schools have already begun teaching more therapeutics in the later clinical-training years; ACP urges all schools to make such changes.

Doctors and medical students should increase their understanding of the evaluation process for new medications, states ACP, and evaluate pharmaceutical industry claims more objectively. ACP further notes that the industry is a major source of drug education for many physicians. Verbal presentation of new-drug information to small groups or individual doctors by an industry sales representative, known as a



“detail man,” has been found highly persuasive; records show that medical residents, who write most hospital prescriptions, tend to prescribe the most recent and novel drugs available.

New diagnostic test for Lyme disease

Researchers at Tufts University have developed the first diagnostic serum test for Lyme disease. The test uses about a dime's worth of a reagent, and takes about 30 minutes to get the results, says one of the researchers — a vast improvement over the former method requiring a \$16,000 microscope and four to six hours of a trained technician's time.

The serum test works like a home pregnancy test. Partially purified antigens are taken from borrelia, the corkscrew-shaped bacteria that cause the disease and are carried by the tick. The antigens are placed in a plastic dish that contains rows of tiny honeycomb pockets. A patient's blood serum is added to the dish. If that mixture turns yellow, the patient has Lyme disease. If it stays clear, no disease.

Approval by the Food and Drug Administration is pending.

Coming soon . . . a contraceptive patch

A proposed contraceptive patch, designed to deliver a controlled dosage of contraceptive hormones transdermally, is presently being tested by Cygnus Research Corporation, a California-based manufacturer of transdermal drug delivery systems.

The patch would last seven days and would be replaced once a week for three weeks. A drug-free patch would be worn for the fourth week to allow for menstruation to occur in much the same way an oral contraceptive does. The difference, however, is that the woman is freed from the need to take a pill each day. Instead, taking the medication will become a weekly event, greatly increasing its convenience while reducing the risk of missed doses.

Because the transdermal patch will probably contain hormones that have been previously approved for contraceptive use by the FDA (reducing the amount of



testing needed for FDA approval) the new patch could be on the prescription market in three to five years.

According to Malcolm Potts, President of Family Health International, a contraceptive evaluation and development organization, “With one million people added to the world's population every five days, we need better methods of contraception. The more methods that are available, the better overall use becomes. A transdermal patch should present less problems and risk less mistakes than the Pill.”

COLLEAGUES

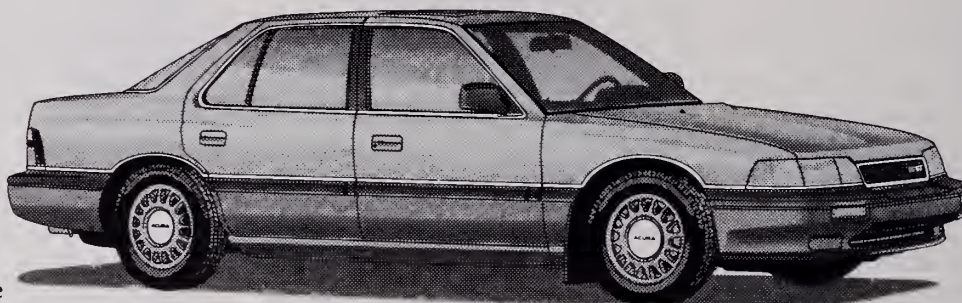
RICHARD C. GLOSH, MD, Lodi, has been named Lodi's Businessman of the Year for 1987. Dr. Glosch was cited for providing medical services to the community since 1960 and for helping develop the Lodi Medical Center . . . **L. TERRY CHAPPELL, MD**, Bluffton, has been elected to a three-year term on the board of directors of the American College of Advancement in Medicine . . . **ROBERT L. FAUL, MD**, a Cincinnati surgeon, has been elected to serve as chief of staff at Mercy Hospital of Fairfield for 1988; **THEODORE HUNTER, MD**, a Hamilton internist, has been elected president of the medical staff at the same hospital . . . **WILLIAM V. MURAWSKY, MD**, Willoughby, has been appointed medical director of the First Urgent Care Center and family practice facility in Cleveland . . . **CHARLES DONLEY, MD**, a Zanesville internist, has been appointed director of medical services at Good Samaritan Medical Center . . . **PAUL N. MASTROS, MD**, Steubenville, has been named chief of staff at St. John Medical Center for the 1988-89 term . . . **CO-LUMBO M. VENETTA, MD**, a Warren general surgeon, has been elected president of St. Joseph Riverside Hospital

medical staff for 1988 . . . **JOEL HOLLAND, MD**, a Shaker Heights cardiologist, has been appointed co-chief of the division of cardiology at Mt. Sinai Medical Center in Cleveland . . . **GEORGE R. BEAUCHAMP, MD**, a Cleveland pediatric ophthalmologist, has been named president of the National Children's Eye Care Foundation . . . **SAMUEL VARGHESE, MD**, Sharonville, has been appointed to serve on the Program Advisory Committee of the American Academy of Otolaryngology Head and Neck Surgery through 1989 . . . **JOSEPH O. OBEDE, MD**, Twinsburg, has been named medical director of the Ashtabula County Medical Center emergency department . . . **WARREN F. MUTH, MD**, a Dayton general surgeon, has been named chief of staff for 1988 at Kettering Medical Center . . . **WILLIAM F. YARRIS, MD**, Fostoria, has received a certificate from the Ohio State Medical Association recognizing 50 years of medical practice . . . **P.K. SOURI, MD**, a Barnesville ophthalmologist, has been elected president of the Belmont County Medical Society for 1989-90 . . . **ROBERT L. CROSS, MD**, a Martins Ferry general surgeon, has been named

president of the medical-dental staff at East Ohio Regional Hospital . . . Greene County Medical Society has elected officers for the new year. They are: **ANGELO SETTEMBRINI, MD**, Xenia, president; **EMERSON HAREWOOD, MD**, Xenia, president-elect; and **WALTER VENABLE, MD**, Fairborn, secretary-treasurer . . . **THOMAS HARDY, MD**, Columbus, chief of surgery at Grant Medical Center, has been presented the American Society of Colon and Rectal Surgeons Research Foundation Award . . . **RICHARD WEINBERGER, MD**, Cleveland, has been elected president of the Cleveland Academy of Family Physicians . . . **JOHN L. SCHOWINSKY, MD**, Zanesville, has been named president of the medical staff at Good Samaritan Hospital for 1988 . . . **RALPH F. HULLER, MD**, Erlanger, has been elected president of the medical staff at St. Elizabeth Medical Center for 1988 . . . **ROBERT HERMAN, MD**, Wapakoneta, has been elected president of the Auglaize County Medical Society . . . **HERBERT S. BELL, MD**, Cleveland, has been elected chairman of the Northwestern Quadrant of the Joint Council of State
continued on page 288

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OHIO MEDI-SCENE

Physicians who make a difference . . . Ohio hospitals make the grade . . . research in Ohio . . . free skin cancer tests . . . UC's new ventilator . . . medicine and humanities . . .

Physicians Who Make a Difference . . .

Editor's note: Presented here are the stories of two Ohio physicians who are stepping above and beyond their medical practices for the betterment of health. From time to time, OHIO Medicine will carry the story of physicians, like Drs. Wehby and Furste, who are making a difference in the quality of health care locally, statewide, nationally or internationally.

Nope to Dope — a phrase of hope

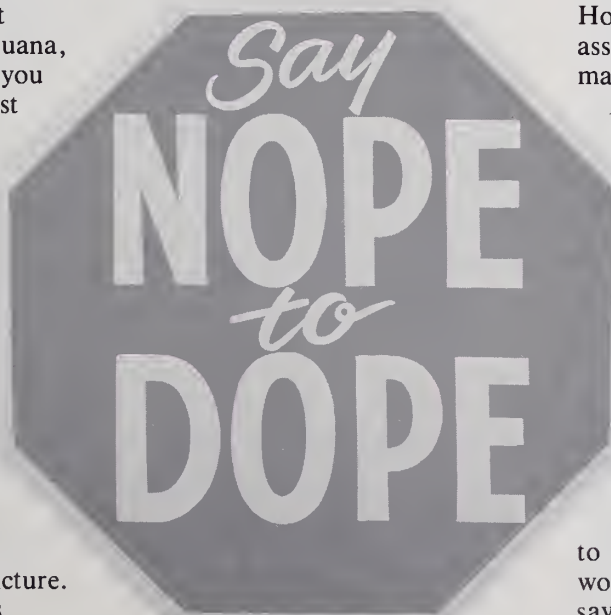
The generation gap. It's a tough nut to crack. For instance, how do you sit down and talk to your kids about drugs? Getting the message to sink in is often the biggest challenge. Whether it's marijuana, cocaine or crack, sometimes you have to hit 'em with your best shot, as an MTV song so bluntly suggests.

Take a current TV commercial in which we see a close-up of a skillet of sizzling, melted butter. The announcer's voice informs: "This is drugs." An egg is cracked and dropped into the high-fry oleo. "This is your brain on drugs. Any questions?"

The hope is that the teenagers of this decade will indeed tune in and get the picture. Whether it's Nancy Reagan's "Just Say No" concept, TV star anti-drug testimonials, or hard-line commercials such as the fried egg scenario and "Cocaine — The Big

Lie" — the message is out there in many different forms.

Now a Cincinnati physician has hopped aboard the anti-drug boat.



He's developed a campaign that he hopes will further illuminate the big picture about drugs, a

campaign that urges adolescents to "Say Nope to Dope."

John H. Wehby, MD, a family practitioner and attending physician at Good Samaritan Hospital in Cincinnati, has assembled an arsenal of anti-drug materials, including *Say Nope to Dope* buttons, badges, stickers and photos, which he's been distributing at schools, conferences and in his practice.

"In the last three to four years, not a day goes by that I don't hand out a number of buttons and badges," he relates.

In fact, at the November 1987 Regional Anti-Drug Conference in Cincinnati, he found out just how popular the Nope to Dope concept could be. "It's a wonder I didn't get trampled," he says. "I gave out 4,000 buttons and badges in less than 30 seconds."

The Nope to Dope motto is
continued on page 264

OHIO MEDI-SCENE

Nope to Dope . . . continued

printed against a red stop sign background — a visual that teenagers can easily recognize and grasp. Dr. Wehby believes his simple, yet direct message has immediate and unforgettable impact.

In September 1987, Dr. Wehby penned a letter to one of his comrades in the fight against drugs, Nancy Reagan, in which he applauded her efforts and offered his support.

He acknowledges that the *Just Say No* campaign is a top-shelf and elaborately orchestrated campaign, but he points out that it addresses a number of distinct

issues. Say no to drugs — and to alcohol, smoking and premarital sex, for example.

Dr. Wehby's campaign, on the other hand, is directed toward illicit drugs, period. Thus, *Say Nope to Dope* hits the problematic nail on the head.

"The youth of this nation are being lost to the effects of illicit drugs," he says, which helps to explain why Dr. Wehby is so adamant about this issue. The youth most in jeopardy are those between ages six and 20, he adds.

But Dr. Wehby and others are hoping to shed some light on the drug dilemma and to put a dent in its armor. "We are trying to unravel the mystery of why people get into this social dilemma," he explains.

Still, the going is slow. It's very difficult to reach teenagers, to understand their social pressures and what makes them tick, he admits.

"Adults really don't understand the youth of this nation. They're (adults) backseat drivers, trying to tell youths how they should feel. Sometimes I think it's harder for an adult to think like a child, to see through a child's eye — even

drug problem, the campaigners against illicit drugs always welcome reinforcements. Dr. Wehby would especially like to see an increase in physician involvement.

"Physicians have been bypassed somehow. They're the silent majority," he says. "But if anyone has the knowledge and experience needed to help with this problem, it's physicians."

One way to break this silence is for the AMA and OSMA to develop their own drug panels — committees that could have a voice at the regional and national anti-drug conferences, he suggests.

"If American physicians had more of an input, they could be a driving force and show direction in this fight. Not having physicians at the conference (the annual White House Conference Against Drug Abuse) is like having a fire at your house and not calling the firemen," he says.

To preserve the minds of this generation, society, including parents, educators and physicians, cannot leave any stones unturned. Dr. Wehby, for one, is committed to make a difference.

As he points out, "When a



John H. Wehby, MD

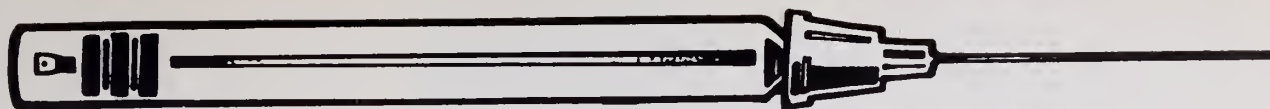
"Adults really don't understand the youth of this nation. They're backseat drivers, trying to tell youths how they should feel."

though they were once children — than it is for a child to think like an adult."

Because of the intricacies of the

disease overcomes society by desperate means, only by desperate means shall it be overcome."

— Deborah Athy



Taming tetanus

Hello. This is Dr. Furste," says the caller. Then, quite unexpectedly, "Do you know when you had your last tetanus shot?"

A strange introduction, perhaps — one that certainly caught this writer off-guard — but if nothing else, Wesley Furste, MD, makes his point, and he does so quickly: Until Americans stop taking tetanus immunizations for granted, the disease will never be eradicated in this country.

For the past 40 years, Dr. Furste has waged a personal campaign to eliminate tetanus completely in the United States — a pretty tall order for some perhaps, but not for this retired Columbus surgeon.

"It's an extremely serious illness," he says. "You get lockjaw, you can't eat, you have severe muscle spasms."

Of course, with proper immunization, tetanus can easily be eradicated. "We have such a fantastic immunization program in the United States," he says, "but our concern is that people are becoming lackadaisical about getting their shots."

To that end, Dr. Furste has become a fervent advocate of regular, timely immunizations — writing literally dozens of articles, essays and editorials expounding the benefits of immunization and encouraging his fellow physicians to ensure their patients' tetanus immunizations are kept up to date.

More specifically, he notes that children should receive a series of tetanus toxoid injections — the first two administered four to six weeks apart and the third given six to 12 months after the second injection — while booster shots should be administered every 10 years after the initial series.

Always one to adhere to his

own advice, Dr. Furste has been known to hand his own patients a wallet-sized immunization record produced by the American Medical Association. "Everyone," he says, "should carry a card stating when they had their last tetanus shot."

Furthermore, he says, the public should not be led to believe that tetanus shots should only be administered in the event of a puncture wound or other similar,

"Most of the cases are in the Southern part of the States," Dr. Furste notes, "because people there are constantly working outside."

Nonetheless, in light of the report, he is confident we will see tetanus eradicated in the next two years.

Says Dr. Furste, "By proper, active tetanus toxoid immunization of all ages — particularly of the older segment — tetanus can indeed become a disease of only historical

"By proper, active immunization of all ages, tetanus can become a disease of only historical significance by 1990."

serious injury. "You don't always give it then because there's the danger of overimmunization," he explains. "You can have a patient become hyperimmunized if you give them too many injections." It is much more desirable, he says, to simply keep up to date on regular immunizations.

Dr. Furste initially became interested in preventing tetanus when he served as an Army surgeon in China during World War II. There he found that many uninoculated Chinese soldiers were dying needlessly from tetanus; when he returned to the States, a one-man war against the disease was born.

Since then, Dr. Furste has predicted several times that the eradication of tetanus was near. This time, however, he is staking his prediction — that tetanus will be wiped out in the United States by 1990 — on a new, exciting revelation: for the first time in the history of the U.S., the number of cases of tetanus has been recorded at less than one per week. In fact, according to a recent issue of *Morbidity and Mortality Weekly Report*, only 40 cases of tetanus were reported in the U.S. during 1987.

significance in the United States by 1990." — Michelle J. Carlson



Wesley Furste, MD

OHIO MEDI-SCENE

Ohio hospitals make the grade

Report cards for Ohio hospitals? Not exactly. But hospitals around the state did receive U.S. Health Care Financing Administration (HCFA) reports on Medicare mortality rates for 1986 — reports that many hospital and medical representatives found to be lacking in substance.

The complete HCFA study, released in December 1987, compared post-admission mortality rates of 6.5 million Medicare patients at 6,000 hospitals nationwide with an expected range of mortality predicted by a statistical model.

While none of the 194 Ohio hospitals in the study exceeded the overall “expected” mortality rates for some 550,000 Medicare patients, some had higher than expected rates in *specific* high-risk categories.

The HCFA report concentrated on 16 diagnoses of death that reportedly account for 70% of Medicare deaths. These categories include cancer, severe acute heart attack, stroke, pulmonary disease, renal disease, severe trauma and severe chronic heart disease.

Some medical spokespersons saw the report as a step toward hospital accountability. Others saw the report as a step that could lead to misconceptions and confusion among the public.

An OSMA press release points out that while the AMA, OSMA and Ohio Hospital Association (OHA) support efforts to improve quality of care, they are concerned that this information may be misused to the detriment of both



patients and hospitals.

“The information . . . may be useful to Peer Review Organizations and hospitals as *one* tool to use to identify potential quality of care problems. However, the information by itself is *not* a measure of quality of care nor can it be used to compare quality between and among hospitals,” the release stated.

The report stirred up opinions from all corners of the state as well. Responses in the media ran the gamut:

“We won’t use the data in any way. It isn’t useful.”

“It’s useful to hospitals.”

“My main emphasis is that the mortality rate is one of about 40 things we watch on a month-to-month basis.”

“The figures show that Ohio hospitals are in pretty good shape.”

“This kind of report is not only going to confuse the patient, but it also has the potential of creating anxiety, because patients don’t know what’s behind the figures.”

“It’s a first step toward getting meaningful data out into the hands of the consumers.”

“If this were a research project

and I was a teacher, I'd say, 'Nice thought, but you didn't do enough.' "

Opponents of the report point out that the findings don't take into account factors such as severity of illness, co-existing illnesses, or hospices, to name a few.

Many factors influence an individual hospital's mortality rate, according to the OSMA and other organizations. Higher than average rates could mean a hospital treats sicker patients or does more high-risk surgeries. Lower than average rates could mean the hospital discharges patients before they die to a long-

"The figures show that Ohio hospitals are in pretty good shape."

term nursing care facility or hospice.

In fact, according to an April 1986 issue of *Medical World News*, the last time HCFA issued hospital mortality rates: "The Nevada hospital with the nation's highest death rate was actually a hospice. A Wisconsin hospital's low death rate was actually the death rate of only one of two hospitals that had merged . . . and a Chicago hospital listed as having a 100% mortality for coronary bypass surgery never performed that procedure . . ."

To be fair, however, HCFA administrators acknowledge that the report is not an official guide for choosing the best hospital, but is only a rough sketch for hospital administrators to use to spot problem areas in specific hospitals.

According to HCFA Administrator William Roper, MD: "While we believe that information on hospital mortality is useful, until we have developed additional statistical measures to deal with complex issues, such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals." — *Deborah Athy*



Photo courtesy of the Upjohn Company

Research in Ohio

New pain drug for cancer patients . . . The University of Cincinnati Medical Center's Pain Control Center is testing a new pain medication designed to relieve the chronic pain associated with cancer. The drug, transdermal fentanyl, is administered through the skin, delivering specific amounts of medication regularly to the patients, up to three days at a time. The new medication is reported to relieve pain without producing the sedation and other side effects associated with the more conventional pain killers.

Treating heart patients more efficiently . . . The Cleveland Clinic is one of five North

American institutions involved in a study to learn how best to clear blockages to the heart, and then, how best to maintain patients' after-care treatment. The first study will focus on those patients who receive newly-formed artery "grafts" through bypass surgery. The eight-year bypass surgery study will employ intensive programs, aimed at getting patients to lower their cholesterol intake, to quit smoking and to lose weight, to determine whether or not patients' lifestyles can affect the need for more surgery, due to occluded grafts.

The second study involves comparing the effectiveness of
continued on page 268

OHIO MEDI-SCENE

Research in Ohio . . .

continued

bypass surgery to coronary angioplasty, and will attempt to determine more precisely which technique would be more beneficial to those patients who can be treated either way. This study will take place over five or six years.

The heart studies are funded through grants provided by the National Heart, Lung and Blood Institute of the National Institutes of Health.

Help for balding heads . . .

Tristate residents with thinning hair are testing a new drug which may encourage new hairgrowth. The new product, called Viprostol, is being tested by 60 men, residents of the Tristate area, under the guidance of the University of Cincinnati Medical Center. Although Viprostol is still in its early testing stages, the FDA has recently approved a similar product, Rogaine, which contains the drug minoxidil. According to studies of that product, only 10 percent of Rogaine's users had sufficient regrowth; 30 percent experienced moderate regrowth; and 60 percent experienced minimal or no growth at all (despite the \$715 a year price tag). Tests on Viprostol will continue for one year.

Schizophrenia studied . . . The cause of depression and other serious mental illnesses is the focus of one study being conducted at Case Western Reserve University's School of Medicine. Since evidence suggests that patients with major depressions or mania have abnormal patterns of Serotonin in

their brains, work is being done to determine why this phenomenon occurs, and how the body compensates for the defect. If successful, the results could improve diagnosis of serious mental illnesses, as well as identifying specific mental problems. The study is being sponsored by the National Alliance for Research on Schizophrenia and Depression.

Calcium channel-blockers . . .

Researchers at Riverside Hospital in Columbus are testing to see whether or not a new drug, a calcium channel-blocking agent, is successful in dilating blood vessels to increase the blood flow to the brain, following cardiopulmonary resuscitation. This is the second study on brain resuscitation that has been performed. The first study investigated the effects of barbiturates in reviving brain activity after a heart attack, however, the drugs proved to be ineffective. Research on the calcium channel-blockers is already complete, and results are expected to be made available by early summer.

New drug for diabetes-related kidney disease . . . Six Ohio hospitals are participating in a study to determine whether the drug captopril, typically used to treat high blood pressure, can help patients with insulin-dependent diabetes mellitus. Those facilities involved in the four-year study include the Cleveland Clinic, University Hospitals of Cleveland, Ohio State University Medical Center and three Canton

institutions — the Canton Medical Education Foundation, Aultman Hospital and Timken Mercy Medical Center. The study is being funded by the National Institute of Diabetes and Digestive and Kidney Diseases and the Squibb Institute for Medical Research. — *Karen S. Edwards*

Editor's note: *OHIO Medicine* would like to hear from you if you are currently involved in a research project, or if you have recently completed research. Please send us a brief report of your work for possible inclusion in a future issue. Send reports to the attention of the Executive Editor, *OHIO Medicine*, 600 South High St., Columbus, Ohio 43215.

Free skin cancer tests

The Cleveland Dermatological Society, in conjunction with the American Cancer Society and WJW-TV 8, will hold a free public skin cancer screening on Saturday, May 21, 1988. Four sites will be used for the tests. For further information, please call the American Cancer Society at 241-1177. Other Ohio cities which will hold skin cancer tests include: Akron, Cincinnati, Columbus, Toledo, Dayton, Medina and Canton. (Watch next month's issue for further details.)

UC tests new, high-frequency ventilator

Few people would be able to guess what adult trauma patients have in common with newborn thoroughbred foals. But for Jim Hurst, MD, of the University of Cincinnati Medical Center, the answer's easy: both have been treated with a new, experimental, high-frequency ventilator.

minute, something that is mimicked by conventional ventilators. However, the latest version of the high-frequency ventilator — it has undergone some 14 or 15 revisions since its introduction in 1979 — can deliver anywhere from 150 to 4,000 “breaths” per minute.

The high-frequency ventilator also exerts much less pressure on the brain than its conventional counterpart — a key consideration when dealing with patients who have sustained severe head or chest injuries.

Dr. Hurst and his colleagues in the medical center's

of two working with adults.

According to Dr. Hurst, prime candidates for high-frequency ventilation include patients with respiratory distress syndrome, patients having problems eliminating carbon dioxide from their bodies, hemodynamically unstable patients, patients with high intracranial pressure, and foals. Yes, *foals*.

Treating newborn thoroughbreds with high-frequency ventilation really isn't so farfetched once you consider that newborn foals fall into a notorious high-risk group.

Dr. Hurst, who has been called to Kentucky on numerous occasions to work with newborn racehorses, explains: “As I understand it, the gestation period for a horse is 11 months and 11 days. But if they foal prematurely, (the foals) are susceptible to the same neonatal distress as (human) infants are.” Namely, lung failure, disease and infection.

Dr. Hurst guesses that the decision to place a newborn foal on ventilation therapy is basically a monetary one — understandable when the foal is expected to someday become a championship racehorse.

Still, says Dr. Hurst, “One

Few people would be able to guess what adult trauma patients have in common with newborn thoroughbred foals.

“It's really a hybrid device,” explains Dr. Hurst, a general surgeon. “It differs from the conventional ventilator in that it delivers rapid ventilation.”

Rapid ventilation may be an understatement. Healthy humans take from 12 to 16 breaths per

department of surgery are one of only four groups in the country that are testing the latest high-frequency ventilators for the Food and Drug Administration, and one

thing we hadn't anticipated was that if the foals didn't respond in a certain amount of time, they were (taken off the ventilator and) sacrificed.”

Fortunately for humans, the amount of time spent on a ventilator depends not upon the patient's prospects of becoming a financial success, but on the

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OHIO MEDI-SCENE

UC tests new ventilator

continued

severity of their illness.

Although most cases of respiratory failure will run their course in 72 hours, Dr. Hurst explains, according to a study conducted at UC, "Most patients will spend an average of about 11 days, plus or minus seven days, on the ventilator." But, he adds, "Some are as short as 12 days, some have literally been on them for months."

While the results of high-frequency ventilation have been encouraging, Dr. Hurst doubts that many new applications will be

found. Because of the nature of the ventilators, he says, "The same groups of patients we are treating now are the ones we'll be using it on in the future."

Nor does he foresee widespread use of the machines. "I would say that the tertiary care centers use them the most," says Dr. Hurst. "They are not in every hospital. I'm just not sure that people other than investigators are willing to take the time to understand and experiment with the machines." —
Michelle J. Carlson

Aging and technology

The Ohio State University will present a national forum/conference series entitled "Technology and Aging" during April and May, 1988. Sponsored by the Ohio State University Department of Industrial Design and the Division of Nursing Staff Development of University Hospitals, the program has three two-day parts. Each part consists of a public forum, to be presented the evening preceding a daylong conference. For more information, please call (614) 292-8571.

Medicine in touch with humanities



Over the past 20 years, study of the humanities has played an increasingly important role in medical education. But until recently, formal training for those who teach medical humanities has been limited.

In response to this need, Northeastern Ohio Universities College of Medicine (NEOUCOM) and Hiram College have joined forces to design a unique Institute for the Humanities in Medicine. Funded by a \$125,620 grant from the National Endowment for the Humanities, the program will involve a week of full-time training, along with several weekend sessions.

Participants will engage in a fellowship program which focuses on the use of literature in teaching medical humanities. The program is entitled "Literary Texts in

Medical Contexts," and focuses on the value of literature in the field of medicine.

Martin Kohn is co-director of the Institute, as well as director of the Human Values in Medicine program at NEOUCOM. When questioned about the value of humanities in medicine, he points out the phenomenal growth in the field over the past 20 years. "In the late '50s, an organized movement began in reaction to the technological development since World War II. That's when people began to think and talk about the responsible use of powerful tools in the field of medicine."

Until that time, the tools available for medical practitioners were limited. With the availability of complex medical tools came complex medical decisions. Doctors were beginning to ask themselves, "How do we fit in what we know we *could* do with what we *should* do?"

Medicine began to look to the humanities, not for answers, but for a conceptual framework to help resolve some of the complicated issues. "The humanities can help us put some of these changes into perspective," Kohn claims. Medical humanities, especially medical ethics and medical law, quickly became an important part of most medical schools across the country.

But where does literature fit in with medicine? Almost everywhere, Kohn replies.

"Literature has had quite an impact in the last five years, because all of the different (humanities) specialties use literature as a vehicle. You can teach medical ethics through the use of literature. You can't avoid the ethical questions when you read literature about health, life and death." It gives discussions depth, allowing a more "real-world" outlook, where issues aren't as simple as they might be in a typical case study.

"Literature promotes vicariousness in ways inaccessible through other medical texts," adds

Delese Wear, another member of NEOUCOM's Human Values faculty who is involved with the Institute. "It helps us feel what it's like to be someone else, whoever that may be. That's what I do in my own teaching, and that's what I hope happens in most of our classes, especially literature." According to Wear, an additional goal of literature and other medical humanities is to help students learn to tolerate ambiguity, which today is so ubiquitous in clinical medicine.

Both Kohn and Wear agree that this is a tall order. But the Institute is a step toward achieving those goals, both in the classroom and the clinical setting.

"We're looking at two groups of people for the Institute: health-care professionals and humanities faculty who have a commitment to teaching health-care students," says Kohn. Thirty fellows are being selected from a pool of applicants which includes teachers of philosophy, theology, ethics, and literature, as well as medical clinicians.

The tremendously varied background of the fellows should be quite an asset, adds Kohn. "We're trying to match up people

with varied backgrounds and interests. Also, because we're appealing to a regional group, we're hoping they'll stay in contact," calling upon one another to aid in presenting the humanities in either the classroom or clinical settings.

Though the fellows will likely come from the Ohio area, the faculty will include several national leaders in the field of

"Literature promotes vicariousness in ways inaccessible through other medical texts."

literature and medicine. John Stone, MD, and L.J. Schneiderman, MD, both physician-authors, head the list, along with Anne Hudson Jones, editor of *Literature and Medicine*.

At present, there are no specific plans to continue the Institute for more than one year. But along with his Hiram College counterpart, Carol Donley, who is the other co-director of the

continued on page 273

In memoriam — Robert A. Lang

Robert A. Lang, EVP Emeritus of the Cleveland Academy of Medicine died February 17, 1988, following an extended illness. He was 69.

From 1958 to 1985, Lang was the Academy's Chief Operation Officer. Following his retirement, he continued to moderate the Academy's Health Lines radio network program which he helped establish many years ago. He was president of AAMSE (the Association of American Medical Society Executives) from 1984-1985.

Lang helped hundreds of physicians to sharpen their

speaking skills under the former AMA Speakers Training Program, directed by Mort Enright. That program prepared physician spokespersons to discuss major issues confronting the profession from 1958-1968 before a variety of public audiences.

Lang earned his BA and MA degrees in speech from Case Western Reserve University in Cleveland and his PhD in speech from Northwestern University. He taught speech at Case Western from 1946-1958.

He is survived by his wife Betty, two daughters and two grandchildren.



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OHIO MEDI-SCENE

Medicine and the humanities . . .

continued

program, Kohn envisions an ongoing commitment for the Institute. The response has already been enthusiastic, and he hopes that the heightened interest in the humanities will lead to funding for another such venture in the future.

At the very least, Kohn continues, "We'd love to be able to develop a good library, clearinghouse, or newsletter to be able to support those who are (teaching humanities) in the clinical setting or in the classroom.

It might be the beginning of a structure . . . to support the humanities in health-care institutes." — **William J. Pomidor, MD**

Author's note: *A seminar on "Literature and Medicine" will be open to the public on May 6, 7, 8. Call Delese Wear, Northeastern Ohio Universities College of Medicine, (216) 678-4160 for more information.*

A new advertising approach

A major pharmaceutical manufacturer has come up with a new way to grab your attention — and hopefully persuade you to prescribe its product.

Sandoz Pharmaceutical Corporation, which has, up until now, advertised its prescription products exclusively in medical journals, is breaking new ground by advertising its Tavist-1, a prescription antihistamine, in a number of newspapers including the *New York Times*, *Los Angeles Times*, *Chicago Tribune* and *The Washington Post*.

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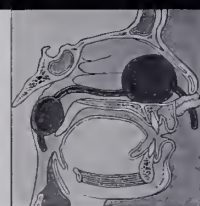
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Epistaxis balloon catheter, page 20

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DECEMBER 1987 / VOL. 9, NO. 12

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KEEPING CURRENT

- | | |
|---|--|
| Does a Definite Diagnosis Help Patients Get Better? | Can Obese Type II Diabetic Patients Use Fructose as a Sweetener? |
| Screening for Liver Metastases | |
| Significance of Elevated Erythrocyte Sedimentation Rates | Comparison of Diagnostic Tests for Evaluating Dementia |
| Glucose Tolerance and Pregnancy Complications Among Nondiabetic Women | Psychiatric Reactions Caused by Lidocaine Toxicity |

CUMULATIVE INDEX

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TAKING CHARGE

1988 Annual Meeting

Candidates for President-Elect

Thomas R. Leech, MD

August 5, 1987

Mr. Herbert Gillen
Executive Director
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Dear Mr. Gillen,

The Lima and Allen County Academy of Medicine is pleased to offer the name of Thomas R. Leech, MD, in nomination for the office of President-Elect of the Ohio State Medical Association.

Dr. Leech is currently the Councilor from the Third District of the OSMA and is serving his sixth year in that office. With his experience on council as well as past President of the Lima and Allen County Academy of Medicine, Delegate to the OSMA and the many OSMA Committees on which he has served or chaired, he has demonstrated the interest and leadership abilities that qualify him for the office of President-Elect of the Ohio State Medical Association.

Sincerely,

D.B. Steiner, MD

President, Lima and Allen County
Academy of Medicine

L.W. Like, MD

Delegate to OSMA

After completing his undergraduate studies at Dartmouth College, Thomas R. Leech, MD, attended Dartmouth Medical School and then received a medical degree from the University of Pennsylvania in 1951.

Dr. Leech interned at St. Luke's Hospital in Cleveland in 1951-52. From there he went to the Ohio State University School of Medicine in Columbus, where he completed residencies in general surgery (1952-55) and in plastic surgery (1955-57).

Dr. Leech combined his undergraduate and medical studies

with a 17-year involvement in the U.S. military service — as a member of the U.S. Naval Reserve. He served on active duty from 1943 to 1946 and then inactive duty until his honorable discharge in 1960.

Since 1957 Dr. Leech has been practicing plastic and reconstructive surgery in Lima, and is on the active staffs of Lima Memorial Hospital and St. Rita's Medical Center.

Throughout his medical career, Dr. Leech has forged a long list of involvements — on the local, state and national level, as well as in civic and social organizations.

Dr. Leech has been a member of the Lima and Allen County Academy of Medicine since 1957 and was president in 1976-77. He was a delegate from Lima/Allen County Academy of Medicine from 1978 to 1982.

His involvement at the state level further illustrates his long-standing commitment to organized medicine. He has been Third District Councilor to the Ohio State Medical Association since 1982. He has served as chairman of the Membership Committee, 1987, the Communications Committee, 1982-84, and of the Ad Hoc Committee on PROs in 1983-84.

Dr. Leech has also been a member of the Task Force on Medical Liability (1984) and its Subcommittee on Loss Awareness, 1987; the President's Committee on PICO, 1987-88; and the Ohio Committee on Trauma since 1975.

He is a member of the American Cleft Palate



Thomas R. Leech, MD

Association, the American Academy of Medical Directors, and has been a member of the American Medical Association since 1957.

Dr. Leech participates in a variety of civic organizations as well — as a trustee for the Lima Technical College since 1975 (chairman 1979-80 and 1987-88), and as a member of the Lima Campus Development Council, the Chamber of Commerce, and the Better Business Bureau. He served as the Lima Fire Department physician from 1977-80 and participated on bimonthly Medical Update presentations on local TV from 1982-86.

Dr. Leech and his wife Gloria reside in Lima. Their daughter Lila will graduate in May from Stephens College in Columbia, Missouri.

William J. Marshall, MD

May 17, 1987

Mr. Herbert E. Gillen
Executive Director
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Dear Mr. Gillen:

The Montgomery County Medical Society is pleased to nominate William J. Marshall, MD, FACC, FACP, as a candidate for the office of President-Elect of the Ohio State Medical Association. Dr. Marshall has demonstrated constructive leadership through various local, state and national medical associations, and his candidacy is unanimously endorsed by the MCMS Board of Directors.

A private practice internist specializing in cardiology, Dr. Marshall is the Director of the Coronary Intensive Care Unit, the Non-Invasive Cardiac Laboratory, and In-Patient Cardiac Rehabilitation at Kettering Medical Center. He is also a clinical professor of Medicine, Wright State University School of Medicine.

Dr. Marshall is committed to heightening physician involvement in organized medicine. As a member of the Montgomery County Medical Society for over 20 years, he has served in the elected positions of President, Treasurer, and Trustee, and has accepted appointments to numerous committees. He presently is Chairman of the MCMS Mini-Internship Committee, a program developed through his initiative to promote communication with non-medical leaders in the community. He served as President of the Ohio Society of Internal Medicine in 1981-82, and is the current President of the Dayton Society of Internal Medicine. His participation in the Ohio State Medical Association includes serving as Second District Councilor since 1984, Chairman of the OSMA Legislative Committee since 1985, and a member of the OSMA Journal Review Committee. In 1986 he was elected to serve as an Alternate Delegate to the American Medical Association.

Dr. Marshall's motivation encourages physicians to make a personal commitment to facing the challenges and opportunities of today's changing medical scene. He has demonstrated outstanding leadership qualifications which make us proud to nominate Dr. Marshall as a candidate for President-Elect of OSMA.

Sincerely,
Walter A. Reiling, Jr., MD
President

William J. Marshall, MD, received his medical degree (graduating magna cum laude) from the University of Maryland in 1958, four years after receiving a BS degree from Muskingum College in New Concord, Ohio. Following an internship at Philadelphia General Hospital during 1958-1959, Dr. Marshall served as junior assistant medical resident, then senior assistant medical resident at Cincinnati General Hospital. He spent the next three years there as a fellow in cardiology, then became an investigator at the Cox Heart Institute in Kettering. Since that time, he has practiced internal medicine, with a specialty in cardiac medicine, in Dayton, and serves as Director of Kettering Medical Center's Coronary Intensive Care Unit, its Non-Invasive Cardiac Laboratory and its Inpatient Cardiac Rehabilitation program. In addition, he is a clinical professor of Medicine at Wright State University, and teaches medical students and residents at Kettering Medical Center.

An active member of numerous medical organizations, Dr. Marshall has served as President of both the Dayton and Ohio Societies of Internal Medicine, as well as President of the Miami Valley Chapter of the American Heart Association. He has also been a long-time board member of the Dayton Area Heart Association.

Dr. Marshall's involvement in both his county medical society and the OSMA, however, has been equally extensive. In 1983, for example, Dr. Marshall was President of the Montgomery County Medical Society, during which time he introduced Project



William J. Marshall, MD

MEND, a program to provide physicians' services to the unemployed of Dayton and Montgomery County. The next year, he replaced Herman I. Abromowitz, MD, as Second District Councilor to the Ohio State Medical Association — a position he continues to hold today. He also serves as an Alternate Delegate to the American Medical Association.

On an academic level, Dr. Marshall has served as Chairman of The Academy of Medicine, Wright State University School of Medicine, and on the School's Executive Committee.

As far as committee work is concerned, Dr. Marshall served as Chairman of the OSMA's Legislative Committee from 1986 to 1987, and has been a member of *OHIO Medicine's* Advisory and Review Board since 1986. He also serves on the Board of Directors at American Physicians Life Insurance Company.

continued on page 288



RICHARD ROBINSON

Richard Robinson, J.D., is a principal in Robinson Widmann Associates — a Mill Valley, California-based health care consulting firm specializing in resources for medical staffs and medical groups. Mr. Robinson's company offers services related to contract evaluation; negotiation with third parties and managed health plans; medical staff leadership, organization and management; dispute resolution between hospitals and medical staffs; and quality assurance.

Until February of 1988, Mr. Robinson was director of the California Medical Association's Division of Physician Contracting and Medical Staff Affairs. Formerly, he was manager of the CMA's Department of Contract Evaluation and Negotiation Services and is author of the revised *Physician's Contracting Handbook*. Mr. Robinson oversaw the establishment of the CMA department of medical staff affairs and was responsible for all CMA policy development and services for medical staffs in California hospitals.

He practiced labor law in Washington, D.C., serving as assistant general counsel for the National Treasury Employees Union and the American Federation of Government Employees. Also, Mr. Robinson has served as an Administrative Law judge for the United State Merit Systems Protection Board.

A graduate of the University of Santa Clara, Mr. Robinson received his law degree from Gonzaga University in Spokane, Washington. He has taught negotiation and dispute resolution at the San Francisco Law School.

Currently, Mr. Robinson is an editorial board member for two national publications — *The Medical Staff Counselor* and *Medical Staff Management*.

Hospital Medical Staff Section Annual Meeting

The Ohio State Medical Association — Hospital Medical Staff Section will hold its Annual Meeting on **Friday, May 20, 1988** in conjunction with the 1988 OSMA Annual Meeting. The OSMA-HMSS meeting will be held at **1:00 PM in Room 213 of the Cincinnati Convention Center, Cincinnati, Ohio.**

The OSMA-HMSS Annual Meeting is an educa-

tional forum, this year focusing on the topic of **"A View from the Trenches: Medical Staff's Fighting Back."** A presentation featuring **Richard Robinson, J.D.**, a principal in Robinson and Widmann Associates, a hospital medical staff and medical group consulting company, will follow a short business meeting.

Schedule (at time of printing)

- 1:00 Business Meeting and Election of Officers, Chaired by Edmund W. Jones, M.D.
- 1:30 Presentation by Richard Robinson, J.D.
- 3:30 Review of OSMA House of Delegates Resolutions
- 4:00 District Caucus
- 6:00 Dinner (on your own)
- 7:00 Opening of the House of Delegates

Candidate for Secretary-Treasurer

Joseph Sudimack, Jr., MD

Joseph Sudimack, Jr., MD, has been nominated for a second term to the office of Secretary-Treasurer of the Ohio State Medical Association. His name was placed in nomination by the Trumbull County Medical Society. On June 30, 1987, Society President Paul G. Zerbi, MD, and OSMA Delegate from Trumbull County John O. Vlad, MD, wrote the following letter:

Mr. Herbert Gillen
Executive Director
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Dear Mr. Gillen:

We are pleased to offer the name of Joseph Sudimack, Jr., MD, as our nominee for a second term to the office of Secretary-Treasurer of the Ohio State Medical Association. The Executive Council of Trumbull County Medical Society unanimously supports his candidacy.

As past President of Trumbull County Medical Society, and having served an unprecedented four-year term as President of Trumbull Memorial Hospital Staff, Dr. Sudimack has demonstrated qualities of leadership, interest in the promotion and advancement of medicine, and a genuine concern for quality health care. He has actively participated in community service and ably represents the medical profession in this county.

Dr. Sudimack has been a Delegate from Trumbull County to the OSMA since 1976, has served on numerous OSMA committees, and has been Chairman of Reference Committees at its annual meetings. He has continued to contribute his considerable leadership capabilities as an AMA Delegate, a position which was supported by his re-election at the OSMA House of Delegates in May, 1987.

We are proud to nominate — for a second term — Joseph Sudimack, Jr., MD, as a candidate for this office.

Sincerely,

Paul G. Zerbi, MD

President, Trumbull County Medical Society

John O. Vlad, MD

OSMA Delegate, Trumbull County,
Sixth District

(Franklin County letter on page 280.)

A native of Bayonne, N.J., Joseph Sudimack, Jr., MD, received his medical degree from the Ohio State University in 1956. He served an internship at Lankenau Hospital in Philadelphia, followed by a residency at the University of Cincinnati, the Institute of Environmental Health and Kettering Laboratory.

Dr. Sudimack is certified by the American Board of Preventive Medicine in Occupational Medicine, is a Fellow of the American College of Preventive Medicine, a Fellow of the American Occupational Medical Association, member of the American Academy of Occupational Medicine, member of the American Public Health Association, and a clinical assistant professor of medicine in the College of Medicine, Ohio State University.

From 1960 to 1987, Dr. Sudimack capably served in the elected position of Trumbull County Coroner. He is a past president of the Ohio Coroners' Association and was on the Board of Trustees of the State Coroners' Association. For 21 years he worked as a solo general practitioner in Warren and held the office of President of the Trumbull County Academy of General Practice. Currently engaged as medical director of the J. Leonard Camera Industrial Rehabilitation Center in Columbus, Dr. Sudimack previously held the appointment of district medical director for LTV Steel Corporation and prior to that, devoted 20 years as district



Joseph Sudimack, Jr., MD

physician for Republic Steel Corporation, Mahoning Valley District.

Dr. Sudimack has spent countless hours committing himself to community service, which is being formally recognized by the Trumbull County Medical Society by placing his name in nomination for the 1987 American Medical Association's Benjamin Rush Award. Dr. Sudimack has been the recipient of the Warren Area Jaycees & Civic Award for Outstanding Community Service and has generously offered his time and talents to organizations including the Trumbull County United Way (President 1985-1986), the Eastern Ohio Heart Association (President 1984-1986), HSAEO (Treasurer 1985-1986) and
continued on page 280

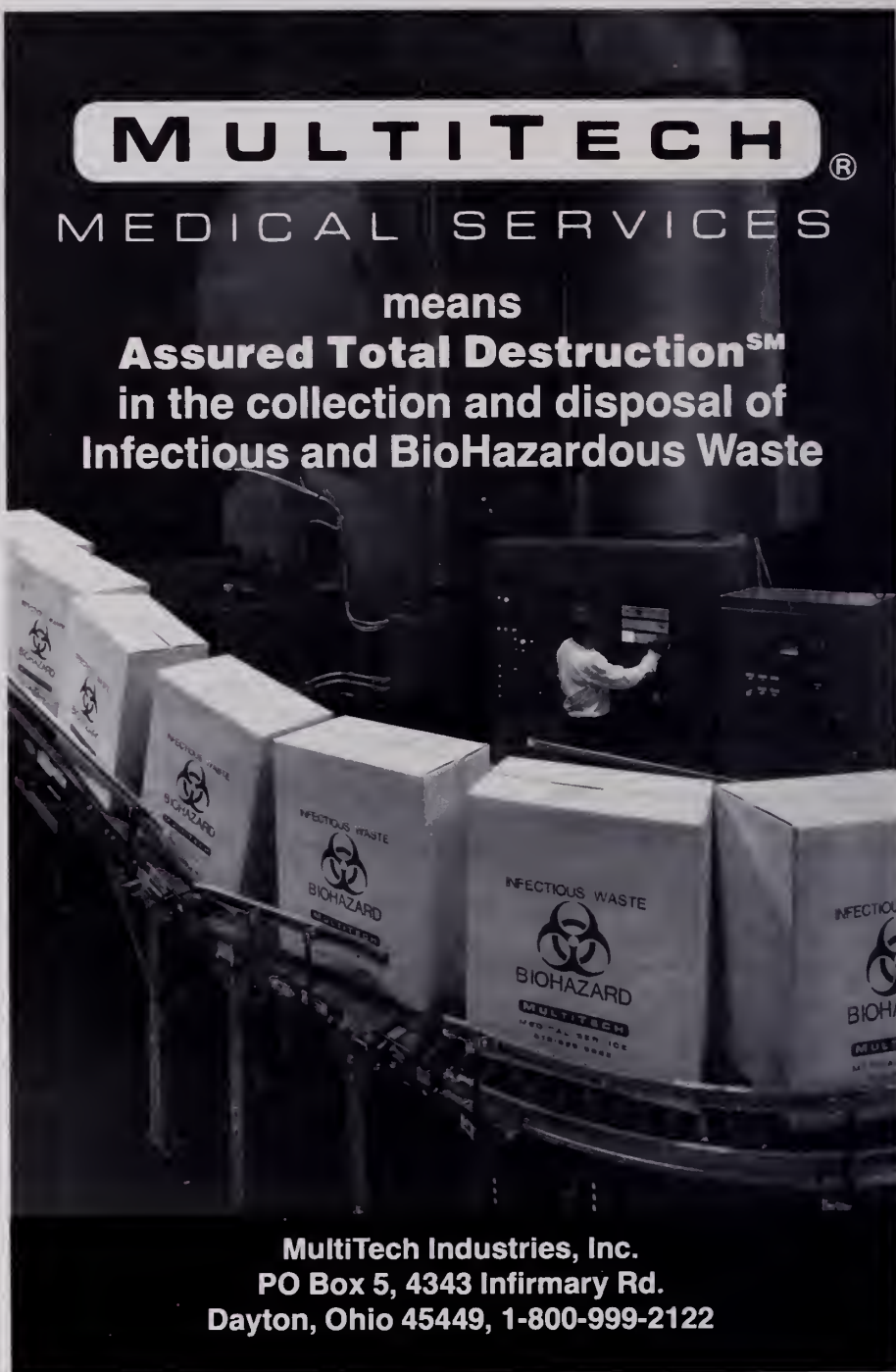
the Warren Area Chamber of Commerce (member, Board of Directors; Vice President 1986).

Dedicating a significant portion of his time to the Ohio State Medical Association, Dr.

Sudimack has earnestly served as Secretary-Treasurer since 1985; he has shared his knowledge of legislative processes with the Sixth District as an OSMA Delegate since 1976, has been chairman of the OSMA House of Delegates Resolutions Committees for two years and a member of Resolutions Committees for six years. Dr. Sudimack was elected by his peers to serve as Ohio Alternate Delegate to the AMA from 1982 to 1986, and was honored by being elected to function as Ohio Delegate to the AMA from 1986 to the present. He has also served on the OMPAC Board of Directors since 1980. The OSMA has called upon Dr. Sudimack to lend his keen insight to various committees over the years including: OSMA Committee on Membership, Audit and Appropriations, Task Force on Competition and Marketing for Physicians, Ad Hoc Committee to Review House of Delegates Policy, Committee on Government Medical Care Programs (Assistant Chairman), Ad Hoc Task Force to Study Leadership Conferences, Interim Sessions and District Conferences, and Medical Licensure Task Force.

Dr. Sudimack has been actively involved with the Trumbull County Medical Society for 28 years, officiating as its President in 1973, in addition to serving on numerous committees and sharing, without reservation, his knowledge — and enthusiasm — with his peers.

Dr. Sudimack resides in Columbus with his wife Linda, and their daughter, Jennifer. Carrying the Sudimack tradition of leadership into the next generation are sons Joseph III, James, Jeffrey and John, and daughters Miriam and Amy Jo. **OSMA.**



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Endorsement letter from Franklin County Academy . . .

Herb E. Gillen
Executive Director
Ohio State Medical Association
600 S. High Street
Columbus, Ohio 43215

Dear Mr. Gillen:

The Council of the Academy of Medicine of Columbus and Franklin County at its Jan. 12, 1988 meeting voted unanimously

to endorse the renomination of Joseph Sudimack, Jr., MD for the office of Secretary-Treasurer of the Ohio State Medical Association.
Sincerely,

Claire V. Wolfe, MD
President, Academy of Medicine of Columbus and Franklin County

The Annual Meeting Format & Schedule

FRIDAY, MAY 20

OSMA COUNCIL MEETING/BREAKFAST

8:30 AM

Room 214, Cincinnati Convention Center

OSMA DELEGATION TO AMA

LUNCHEON/MEETING

12:00 Noon

Room 208, Cincinnati Convention Center

HOSPITAL MEDICAL STAFF SECTION

MEETING

1:00 PM

Room 213, Cincinnati Convention Center

RESOURCE CENTER

11:00 AM-7:00 PM

Second Level, North Foyer, Cincinnati Convention Center

HOUSE OF DELEGATES

3:00-7:00 PM

Registration, Second Level, North Foyer, Cincinnati Convention Center

4:00-5:30 PM

Councilor District Caucus Meetings

Posted at Registration Desk

North Foyer, Second Level, Cincinnati Convention Center

6:00-6:45 PM

Dinner, Grand Ballroom, Clarion Hotel

7:00 PM

Opening Session, Room 210, Cincinnati Convention Center

AFTER HOUSE OF DELEGATES

ADJOURNMENT

Reception and Entertainment

Cosponsored by Academy of Medicine of Cincinnati; and

Business Information Services, Inc.

Grand Ballroom, Clarion Hotel

ORDER OF BUSINESS

OPENING SESSION

Call to Order

D. Ross Irons, M.D., Bellevue

President

Invocation

Welcome

K. William Kitzmiller, M.D.

President, Academy of Medicine of Cincinnati

Parliamentarian

W.J. Lewis, M.D., Dayton

Report

Committee on Credentials

Consideration of Minutes of 1987 Annual Meeting

(See August 1987 issue of *OHIO Medicine*)

Introduction of Member, AMA Board of Trustees

Introduction of Presidents of Other State Societies

Introduction of Honored Guests

Introduction of Representatives of Allied

Organizations

Membership Outreach Program

Thomas R. Leech, M.D., Lima

Chairman

Auxiliary Report

Mrs. Joyce Johnson, Columbus

OSMA Auxiliary President

AMA-ERF Presentations

D. Ross Irons, M.D.

President

Presentation of Plaques

To past Councilors, retiring AMA Delegates and Alternates and Chairmen of Committees

Announcement

D. Ross Irons, M.D.

Appointments to Resolutions Committees,

Credentials, and Tellers and Judges of Election Committee

Election of Committee on Nominations

On the first day of the Annual Meeting the House of Delegates shall elect a Committee on

Nominations consisting of one delegate from each councilor district. The chairmanship of the

Committee on Nominations shall be rotated in numerical order annually among the Councilor

district representatives on such Committee. (NOTE:

The 1988 Nominating Committee Chairman will be the representative from the Third Councilor

District). The Committee on Nominations shall report to the House of Delegates a ticket containing

the name of one or more members for each of the offices to be filled at that Annual Meeting except

that of President-Elect. Prior to selecting a ticket the Committee shall hold hearings which shall be

open to all members in good standing of this

Association. Any member in good standing shall

continued on page 282

Annual Meeting Format and Schedule . . . continued

have the opportunity to appear before the Committee regarding any proposed candidate. The Committee may request an interview with any proposed candidate or with any member concerning such proposed candidate's qualifications. Each nominee must have a majority vote of the Committee in order to be placed on the ticket for presentation to the House of Delegates. Each nominee for Councilor must be a resident of the councilor district for which he is nominated. Delegates and Alternate Delegates to the American Medical Association shall be elected at large.

Presidential Address

D. Ross Irons, M.D.

Special Order of Business

Memorial Resolutions

Introduction of Resolutions

Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Sunday afternoon session before any action can be taken.

Committee on Emergency Resolutions

Report

Miscellaneous Business

SATURDAY, MAY 21

OMPAC BOARD MEETING/BREAKFAST

7:00-8:00 AM

Ivory B, Clarion Hotel

REFERENCE COMMITTEES

7:00 AM

Breakfast, Grand Ballroom A & B, Clarion Hotel

8:00-11:30 AM

Hearings, Convention Center

Committee No. 1, Room 212

Committee No. 2, Room 213

Committee No. 3, Room 210

& President's Address

Nominating Committee, Room 207

9:00 AM-12:00 Midnight

Writing Reports, Convention Center

Committee No. 1, Room 214

Committee No. 2, Room 215

Committee No. 3, Room 204

& President's Address

OMPAC

11:15 AM-2:00 PM

Social Hour & Luncheon

\$25 per person

Grand Ballroom A & B, Clarion Hotel

CANDIDATE INTERVIEWS

2:30-5:00 PM

Schedule and times will be posted at registration

YOUNG PHYSICIANS COMMITTEE

2:00 PM

Room 200, Cincinnati Convention Center
ALL MEMBER RECEPTION

6:00-7:30 PM

Grand Ballroom A & B, Clarion Hotel

ON YOUR OWN

Evening

Free for members to make own dinner arrangements

SUNDAY, MAY 22

COUNCILOR DISTRICT CAUCUS

8:00 AM-12:00 Noon

Schedule and times will be posted at registration

HOUSE OF DELEGATES

11:30 AM

Registration, Second Level, North Foyer,
Cincinnati Convention Center

1:00 PM

Final Session, Room 210, Cincinnati Convention Center

6:00 PM

Dinner, Grand Ballroom A & B, Clarion Hotel

7:00 PM

Resume Final Session, Room 210, Cincinnati Convention Center

ORDER OF BUSINESS

FINAL SESSION

Introduction of Guests

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

Joseph Sudimack, Jr., M.D., Columbus

Incumbent Secretary-Treasurer for a three-year term

Election of Members of The Council

Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years.

First District: Incumbent, Stanley J. Lucas,

Cincinnati; Third District: Incumbent, Thomas R.

Leech, Lima (not eligible for re-election); Fifth

District: Incumbent, Henry G. Krueger, Cleveland;

Seventh District: Incumbent, Nermin D. Lavapies,

Martins Ferry; Ninth District: Incumbent, Thomas

P. Price, Jr., Gallipolis (eligible for re-election, but

chooses not to run); Eleventh District: Incumbent,

Charles G. Adams, Vermilion.

Election of Delegates and Alternates to the AMA

Nine Delegates to be elected for a two-year term starting January 1, 1989, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates will serve for the remainder of 1988, their terms expiring December 31, 1988.

Delegates (listed alphabetically):

Herman I. Abromowitz, Dayton; Theodore J.

Castele, Cleveland; Roland A. Gandy, Jr., Toledo; Jerry L. Hammon, Dayton; Stanley J. Lucas, Cincinnati; Thomas W. Morgan, Gallipolis; Richard J. Nowak, Cleveland; H. William Porterfield, Columbus; and one vacancy created by the resignation of Robert G. Thomas, Elyria. A term commencing May 22, 1988 and ending December 31, 1989 created by the election of Oscar W. Clarke to the AMA Council on Ethical and Judicial Affairs, is to be filled.

The President of the Ohio State Medical Association and Chairman of the Ohio Delegation to the American Medical Association recommend to the OSMA Council that OSMA's total complement of Alternate Delegates be set at 14 rather than 18. The reason for this recommendation is to allow for a convenient and simplified method of reducing the Delegation allocation in 1989 if certain membership criteria are not met. Further, OSMA currently has 16 Alternate Delegates. The number of the Alternate Delegates could be reduced to 15 on 5/22/88 as Dr. Clarke's Delegate position is filled by an Alternate Delegate and that Alternate Delegate vacancy is not filled. The number of Alternate Delegates can further be reduced to 14 on 1/1/89 as Dr. Thomas' Delegate term expires and the position is filled by an Alternate Delegate and that Alternate Delegate vacancy is not filled. It is also recommended that any additional Alternate Delegate positions created through resignation or inability to fulfill the duties of that office not be replaced at the 1988 Annual Meeting. These recommendations will be acted upon by the OSMA Council on March 26, 1988.

In accordance with Chapter 5, Section 7 of the OSMA Bylaws, an Alternate Delegate will be elected by the OSMA Medical Student Section on February 27, 1988.

Listed below are the incumbent Alternate Delegates whose terms end 12/31/88. Incumbent Alternate Delegates choosing to seek re-election for term commencing 1/1/89 and ending 12/31/90 must run for re-election at the Annual Meeting. The following Alternate Delegates are eligible for re-election:

Edmund C. Casey, Cincinnati; Jerome Kimmelman, Toledo; Henry G. Krueger, North Olmsted; William J. Marshall, Dayton; Raymond J. McMahon, Jr., Massillon; S. Baird Pfahl, Jr., Sandusky; Walter A. Reiling, Jr., Dayton; Lee J. Vesper, Cincinnati.

All nominees for the offices of AMA Delegates and Alternate Delegates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

SPECIAL ORDER OF BUSINESS

Installation of 1988-1989 Officers

Reports of Reference Committees

Resolutions Committee No. 1;

Resolutions Committee No. 2;

Resolutions Committee No. 3 and President's Address.

Miscellaneous Business

Announcements

Donavin A. Baumgartner, Jr., M.D., Cleveland
President

Unfinished Business

Adjournment

MONDAY, MAY 23

OSMA COUNCIL MEETING/BREAKFAST

8:30-10:00 AM

Bronze B, Clarion Hotel

PICO SHAREHOLDERS MEETING

10:00 AM

Bronze A, Clarion Hotel

OMERF MEETING

10:30 AM

Commodore Room, Clarion Hotel

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U.S. Army	252

Members of 1988 OSMA House of Delegates

FIRST DISTRICT

ADAMS COUNTY

Delegate:

Dale L. Mathias

Alternate:

BROWN COUNTY

Delegate:

Charles W. Hannah

Alternate:

BUTLER COUNTY

Delegates:

Louis L. Barich
Albert S. Palatchi
John J. Ryan

Alternates:

Mark E. Frazer
Gregory L. Savage
William M. Stitt

CLERMONT COUNTY

Delegate:

William B. Selnick

Alternate:

Donald R. Williams

CLINTON COUNTY

Delegate:

C.T. Hu

Alternate:

Edwin P. Hiatt

HAMILTON COUNTY

Delegates:

Sabino T. Baluyot
Richard B. Budde
Edmund C. Casey
Judith S. Daniels
Ronald H. Fegelman
Harry H. Fox
Kenneth A. Frederick
William H. Gates
Stephen P. Hogg
K. William Kitzmiller
Edward J. Kremchek
Herbert D. Long, Jr.
Herbert G. Magenheimer

Walter E. Matern
Robert J. McDevitt
William C. Miller
Harold Pescovitz
Daniel E. Santos
Lee J. Vesper
Stanley J. Wacksman
Thomas R. Werner
S. Marcus Wigser
Walter B. Wildman, II

Alternates:

I. Leonard Bernstein
Frank W. Cianciolo
Betty Lou Eilers
Josef E. Fischer
Z. Charles Fixler
Joe N. Hackworth
Thomas Helmsworth
Clyde E. Henderson
Edmund W. Jones
David Marc Kesterson
W. John Kitzmiller
Kris Mahalingam
James M. Marrs
Frank E. McWilliams, II
Richard P. Morin
Pramod R. Rege
James E. Schmidt
John C. Steiner
William D. Tobler
Susan Weinberg

HIGHLAND COUNTY

No active Society

WARREN COUNTY

Delegate:

Carl Durning

Alternate:

Walter Meyer

SECOND DISTRICT

CHAMPAIGN COUNTY

Delegate:

John H. Flora

Alternate:

J. Steven Polsley

CLARK COUNTY

Delegates:

Carlos Andarsio
Walter R. Lawrence

Alternates:

Paul E. Andorfer
Paul S. Buchanan

DARKE COUNTY

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Alan Palmer

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Jerome Kimmelman
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Lance A. Talmage
Richard J. Wiseley
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Alcuin D. Bennett
Leo J.P. Clark
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Robert J. Navarre, Jr.
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Alternate:

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Alternate:

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Alternate:
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Alternate:
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Alternate:
Luana J. Hess

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Alternate:
James P. Farmer

CUYAHOGA COUNTY

Delegates:
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Victor M. Bello
Wilma F. Bergfeld
Leon A. Brown
John H. Budd

continued on page 287

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection: Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B

Date of issuance Apr. 1987

SK&F LAB CO.

Cidra, P.R. 00639

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In peptic ulcer:

RELIEF

REASSURANCE

REWARD



Tagamet®
brand of cimetidine
First to Heal

You'll both feel good about it.

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Pratop Souri

Alternate:

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Alternate:

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Delegate:

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Alternate:

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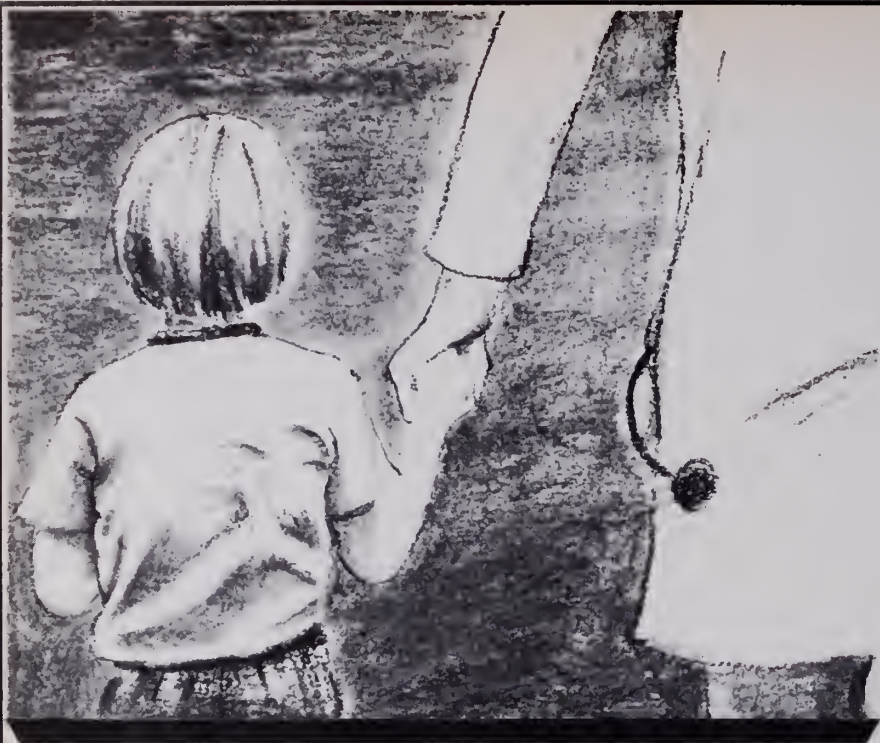
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continued on page 290



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William Marshall, MD

continued

On a local level, Dr. Marshall's participation in projects spans a wide range of interests. For example, he is Chairman of the Montgomery County Medical Society's highly-successful Mini-Internship program, a position he has held since 1984, and has also served on the county society's Indigent Health Care Committee. In fact, Dr. Marshall was instrumental in initiating OSMA's "OPEN" program. In addition, Dr. Marshall has also been involved at various levels with the Miami Valley Health Care Coalition. He also serves on the board of the Combined Health District of Montgomery County.

A widely-published author, Dr. Marshall continues to contribute articles regularly to *Dayton Medicine*, the publication of the Montgomery County Medical Society.

An avid fisherman, and member of the Rod and Reel Club, Dr. Marshall enjoys annual fishing trips with fellow fishermen of the Oakwood Fur, Fin and Feather Club.

Dr. Marshall and his wife Barbara reside in Dayton with their three daughters, Elizabeth, Catherine and Ann. OSMA

Colleagues in the News

continued

Neurosurgical Societies . . . **LIWANAH ASUNCION, MD**, a Lorain internist, has been elected the first president of the newly-formed Lorain County Women's Medical Society . . . **VERNON DEAN STEPHENS, MD**, Woodsfield, a semi-retired otolaryngologist, has been listed in a recent edition of *Who's Who in Medicine* . . . **GILBERT SCHIFF, MD**, Cincinnati, has been elected vice president of the Association of Independent Research Institutes . . . **GEOFREDO ACCETTA, MD**, Cincinnati, has been named Citizen of the Year for 1987 by the Anderson Area Chamber of Commerce . . . **RAYMOND R. SUSKIND, MD**, Cincinnati, director emeritus of the Institute of Environmental Health, University of Cincinnati, has received from the American Academy of Occupational Medicine the Robert A. Kehoe Award of Merit for outstanding contributions to the field of occupational medicine.

PAUL E. GILLMOR

PRESIDENT OF THE OHIO SENATE

To Address OMPAC Luncheon

Saturday, May 21

Reception: 11:15 AM

Luncheon: 12:00 Noon

Grand Ballroom A & B, Clarion Hotel
Cincinnati, Ohio

State Senator Paul E. Gillmor, now serving his sixth term in the Ohio Senate, is the President of the Ohio Senate for the 117th Ohio General Assembly.

Unanimously elected Republican leader of the Ohio Senate five times, Senator Gillmor also served as the President of the Senate during the 114th and the 116th General Assemblies. The National Republican Legislators Association selected him as one of the ten most outstanding legislators in the United States.

Senator Gillmor has also received distinguished service awards from the Disabled American Veterans of Ohio, the Ohio Civil Service Employees Association, the Medical College of Ohio at Toledo, and the Ohio Department of Aging. Senator Gillmor also holds the prestigious Governor's Award, the Phillips Medal of Public Service, and has been inducted into the Ohio State Fair Hall of Fame.

Senator Gillmor, his wife Karen and two daughters reside in Port Clinton, Ohio.

Senator Gillmor represents the 2nd Senatorial District, which includes parts of Erie and Lucas Counties and all of Ottawa and Wood Counties.

To make reservations to attend the OMPAC Luncheon, please complete the attached form and return it with your check for \$25 for each ticket to the Ohio State Medical Association.



OMPAC

LUNCHEON RESERVATIONS

OSMA Annual Meeting, Saturday, May 21, 1988

Please print:

Name _____

No. of Tickets

Address _____

_____ \$ _____

\$25 per person

City _____ State _____ Zip _____

Telephone (____) _____

Make checks payable to: Ohio State Medical Association

Mail to: Ohio State Medical Association
Department of Administrative and Educational Services
600 South High Street
Columbus, Ohio 43215

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Edward T. Bope

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Alternate:

Max R. Hickman

UNION COUNTY

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Mary Pedersen

Alternate:

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Raj N. Ravindra

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Alternate:
M. Robert Huston

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Alternate:
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Nicandro V. Leano
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Alternate:

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PORTAGE COUNTY

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Alternate:
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E. Gates Morgan
A. E. Villalba
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Past President	John E. Albers
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Tenth District	H. William Porterfield
Eleventh District	Charles G. Adams
Twelfth District	Jack L. Summers

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Resident Physician Section	Frederick S.B. Rayne

ASK THE OMBUDSMAN

Q. Medicare makes errors in reimbursement on my surgical claims, especially those which are extensive services or multiple procedures. I send operative notes with each claim, but the errors continue and I am forced to appeal each one. Is there a better way?
MD, Southern Ohio

A. Nationwide-Medicare might be able to provide quicker service and more accurate reimbursement if you will send claims with operative notes to a special mailing address:
Medicare Operations
P.O. Box 182060
Columbus, Ohio 43216
Ombudsman

Q. Medicare (and other carriers) offer toll-free telephone lines for physicians, which are constantly busy, and the non toll-free lines almost always provide a recording asking me to hold, at my expense, for an indefinite period of time for the next available representative. I am extremely frustrated by the inability to communicate with these carriers over the telephone. What can be done?
MD, Dayton

A. We appreciate your concern, and you are correct. Telephone inquiries to carriers are becoming less attractive as a method to resolve problems. Most carriers suggest that they are better equipped to handle written inquiries, however, we find failure in this method also. If you choose to use the toll-free numbers, we have determined the best times to call carriers are between 8:00-10:00 a.m. and 3:00-4:00 p.m.

Ombudsman

County Medical Societies

Officers, Executive Directors and Meeting Dates

FIRST DISTRICT

Councilor: *Stanley J. Lucas, M.D.*,
2905 Burnet Ave., Cincinnati
45219.

ADAMS: Dale L. Mathias,
M.D., President and Secretary-
Treasurer, 195 Hopping Ave.,
Peebles 45660-1079. Second
Tuesday, February, May, August
and November.

BROWN: Jeffrey S. Donohoo,
M.D., President, 111 W. Cherry
St., Georgetown 45121; Tim
McKinley, M.D., Secretary-
Treasurer, 408 Smith Rd., Mount
Orab 45154-9416. Fourth Tuesday.

BUTLER: Alvin H. Niemer,
M.D., President, 50 N. Breiel
Blvd., Middletown 45042-3804;
Jeffrey Zollett, M.D., Secretary-
Treasurer, 28 S. Clinton Ave.,
Middletown 45042-4172; Badonna
Reese, Executive Secretary, 111
Buckeye St., P.O. Box 1067,
Hamilton 45012, 513/893-1410.
Third Wednesday, October through
May.

CLERMONT: Deborah A.
Maham, M.D., President, 243 Gay
St., Williamsburg 45176-1334;
William B. Selnick, D.O.,
Secretary-Treasurer, Second & E.
Loveland Aves., Loveland 45140.
Third Wednesday except July and
August.

CLINTON: Janet Gick, M.D.,
President, 222 W. Main St.,
Wilmington 45177; Keith B.
Holten, M.D., Secretary-Treasurer,
1184 W. Locust St., Wilmington
45177-2009; Marilyn S. Walker,
Executive Secretary, 119 Old Route
122, Lebanon 45036, 513/382-9250.

**These societies have early elections.*

Fourth Tuesday except July,
September and December.

HAMILTON: K. William
Kitzmiller, M.D., President, 9500
Kenwood Rd., Cincinnati
45242-6140; Clyde E. Henderson,
M.D., Secretary, 3333 Vine St.,
Suite 700, Cincinnati 45220;
William J. Galligan, Executive
Director, 320 Broadway, Cincinnati
45202, 513/421-7010. Second
Tuesday except July and August.

HIGHLAND: No active county
medical society.

WARREN: Jan Perry Knisely,
M.D., President, 1618 Deerfield
Rd., Lebanon 45036-9676; Walter
Meyer, M.D., Secretary, 1004
Oregonia Rd., Lebanon
45036-9740. Second Tuesday.

SECOND DISTRICT

Councilor: *William J. Marshall*,
M.D., 2600 Far Hills Ave.,
Dayton 45419.

CHAMPAIGN: Jae J. Koh,
M.D., President, 27 Rue Saint
Charles, Urbana 43078-2314; Sher
S. Guleria, M.D., Secretary-
Treasurer, 900 Scioto St., Urbana
43078-2226. Second Wednesday,
February, April, May, then as
needed.

CLARK: David L. Lawrence,
M.D., President, 402 N.
Broadmoor Blvd., Springfield
45504-1124; Marios Panayides,
M.D., Secretary, 444 W. Harding
Rd., Springfield 45504-1793;
Roberta Farish, Executive
Secretary, 34 W. High St., Room
710, Springfield 45502,
513/324-8618. Third Monday.

DARKE: Keith E. Ashbaugh,

M.D., President, 7603 Celina Rd.,
Greenville 45331-1052; Carlos K.
Menendez, M.D., Secretary, 7603
Celina Rd., P.O. Box 747,
Greenville 45331-1052. Third
Tuesday.

GREENE: Angelo Settembrini,
D.O., President, 1099 W. Second
St., Xenia 45385-3713; Walter G.
Venable, M.D., Secretary-
Treasurer, 562 E. Dayton
Yellow Springs Rd., Fairborn 45324;
Judith L. Khoi, Executive
Director, 1141 N. Monroe Dr.,
Room 235, P.O. Box 217, Xenia
45385-0217, 513/376-3783. Second
Wednesday, March, June,
September and December.

MIAMI: Dean Allen Landes,
M.D., President, 3130 N. Dixie
Hwy., Troy 45373-1337; Donald P.
Luna, M.D., Secretary, Piqua
Memorial Hospital, 624 Park Ave.,
Piqua 45356-2098; Beverly J.
Gheen, Executive Secretary, 20
South Lane, Troy 45373,
513/339-0814 Tuesday and
Thursday mornings. First Tuesday,
September through June.

MONTGOMERY: Konrad
Kircher, M.D., President, 5032
Marilake Circle, Dayton
45429-5416; Watson D. Parker,
Jr., M.D., Secretary, 1001
Runnymede Rd., Dayton
45419-2919; Richard G. Tapia,
Executive Director, 40 S. Perry
St., Suite 100, Dayton 45402,
513/223-0990. Fourth Thursday
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Events in the Queen City

While you're discovering Cincinnati, why not take in a ballgame, a concert, or any one of a number of activities planned for that weekend? Here is a sampling of the events offered. Check local newspapers, or with the hotel to learn of other events not mentioned here. And don't forget to make reservations, or place your ticket order early.

— *Maifest '88* — May 20-22. This annual event celebrates the first spring wines, as well as the beginning of the festival season. Crafts, food and live entertainment are also featured. MainStrasse Village, Exit 192 off I-75/71, Covington, Kentucky.

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**“The secrets of the cell are
beginning to yield to the new biology . . .”**

Reproduction Technology: Cataloging the Criticisms (Part II)

The Medical Views

Editor's note: Last month, we explored the subject of reproduction technology in-depth, and printed both the views of an ethicist and an appellate court judge on the ethics involved in this area. This month, we follow up with the views from two physicians, both eminently qualified to review this topic for us.

An ethics professor's view . . .

By Stanley B. Troup, MD

The past decade has provided an increase in knowledge of human biology that probably is unprecedented for a similar period of time in history. The secrets of the cell are beginning to yield to the new biology. The identification,

chemical dissection and molecular analysis of genetic material represent the most startling area of advance. Numerous human genes have been isolated, cloned and their chemical structure identified. The products of these genes also have been identified and

characterized. Some have proven to be growth factors. Others have proven to be cellular membrane receptors for cellular growth factors. Yet other of the gene products are enzymes critical to normal cellular function.

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Understanding of cellular differentiation, cellular growth and organization, while incomplete, is emerging. Interestingly, the successful probing for such fundamental information has raised surprisingly little public concern on the part of ethicists. In all probability, the successes have not been overlooked. Rather, their attention has been commanded by the remarkable technological achievements in the field of reproductive biology.

The results of these latter advances are more immediate, both in the temporal and the emotional sense. The long-term consequences of gene cloning are no less profound than the ability to fertilize in vitro, store, preserve and successfully transplant a human embryo. The impact of the latter, however, on our consciousness, the direct challenge to conventional morality and religious values, are such that the attention of the public, and, inevitably, the government, focuses on reproductive science to the lessening of attention to genetic science. In fact, the fields are naturally and inextricably linked and the ethical spotlight, sooner or later, will focus on the latter as well. In the meantime, however, the questions derivative of the newly-created possibilities in reproduction and surrounding events demand discussion.

It might be of value to review the topic of reproduction rather

broadly and try to identify those areas where new understanding or new technology have attracted interest. This preface is an attempt to understand the ethical implications of the technology and responses to it, and to venture some guesses as to whether these responses are likely to lead to regulatory or legislative efforts that would influence personal or professional practices.

For many years males and females alike have been treated

“Except where religious prohibition exists, the ethical concerns attendant to contraception are minimal.”

with hormones in an attempt to increase fertility where evidence or clinical suspicion has suggested that hormonal deficiency or imbalance has been responsible for the lack of fruitfulness. These efforts have not been the subject of ethical concern. In recent years, however, the use of new agents that lead to multiple, simultaneous ova maturation and release have become commonplace. Their use helps account for an impressive increase in the number of multiple births.

By itself, this has attracted modest interest. Recent disclosures, however, about intervention to selectively reduce by abortion the number of developing fetuses in some such cases has attracted wide attention and raised concern in some quarters. Thus, the use of hormones to increase fertility has not been a cause of concern, *per se*, but the consequence of their use now raises substantial ethical questions.

Except where religious prohibition exists, the ethical concerns attendant to contraception are minimal. Interestingly, developmental efforts to produce and test a post-coital contraceptive (a contradiction in terms?) also have attracted less attention than one might have anticipated. If and when such products become widely available it seems likely that interest may mount. Here the argument would center on whether prevention of implantation of the fertilized ovum is tantamount to abortion. Shedding of a previously implanted fertilized ovum undoubtedly would be interpreted as abortion by those to whom union of gametes represents the creation of a new being.

Within the past several years, the topic of surrogate motherhood has been examined and debated, not only in the media but in the courtroom as well. While the practice of male surrogacy is still

unacceptable to some, the arguments appear to be those of moral theology rather than on the basis of more broadly based ethical principles. The questions attendant to surrogate motherhood, however, are more complex and invite legislative attention. As the courts wrestle with these difficult questions, increasing pressure will fall upon legislative bodies to provide more precise guidelines.

Concern is not focused alone on the relative merits of biological versus social claims. Concern also has been expressed about the processes of identification and recruitment of the surrogate mother. Here, inevitably, the questions are couched in pecuniary terms. If one accepts the ethical legitimacy of surrogate motherhood, questions remain about the rewards or reimbursement to be offered to the surrogate mother. Gestation and birth, under the most favorable of circumstances, are not altogether free of risk to the mother. Should payment be permitted to any third party involved in recruitment? If so, should any limits be imposed? In what ways can the surrogate be rewarded? Can a sum of money be identified that will be interpretable as compensation for risk but not so large as to be viewed as seduction into the surrogacy? The implications of the latter are profoundly troubling to many who are otherwise willing to accept an ethical basis of surrogacy. These are but some of the questions for which answers may be sought by legislative action.

The most dramatic and popularly reported technological achievements in the field of reproductive physiology recently have centered upon the successes with in vitro fertilization, embryo preservation and embryo transplantation. These Brave New World phenomena, dramatic as they are, have presented medical ethicists, jurists and, potentially,

legislators with a broad array of questions that must be confronted and for which acceptable answers must be developed. We already have witnessed a bizarre and tragic international episode wherein a husband and wife arranged for in vitro fertilization of the wife's ova. The embryos then were preserved. A short time later the couple perished in an airplane

application of that new knowledge to another field, related or not. A shortcoming of that transfer of knowledge — or technology — in the case of medicine, is that the application of the new knowledge or a new technology sometimes blurs the borders between values that have proven acceptable and those that have been rejected.

Such may be the case now that

“These Brave New World phenomena have presented medical ethicists, jurors and, potentially, legislators with a broad array of questions . . .”

crash. Litigation followed concerning identification of responsibility for the cryopreserved embryos. Australian judges finally ruled that the embryos could be destroyed. The tangled possibilities that can emerge as a consequence of these new technical capacities seem limitless. Again, ethical evaluation of these new possibilities for procreation generally has resulted in acceptance except where theological interpretation has found them wanting.

The ethical aspects of abortion have been debated for many, many years. At this juncture it is not likely that significant philosophical changes in reasoning are likely to take place. The arguments have largely departed the philosopher's den and probably are now less influenced from the pulpit as well. Rather, the loci of decision-making rest within various levels of governmental administration, with legislative bodies whose actions define the degrees of freedom within which administrative actions may take place, and the courts.

As is true of knowledge developed in any discipline, an extra dividend is the possible

transplantation of fetal cells is being considered as therapy. The biochemical defect, at least in some patients with Parkinson's disease, is the failure of cells of the substantia nigra to elaborate dopamine. Animal studies and, more recently a few experimental human studies, suggest that the implantation of appropriate fetal central nervous system cells will lead to dopamine synthesis and clinical improvement. The controversy surrounding the use of fetal cells has to do with the obtaining of the cells rather than with their use.

Fear is expressed, for example, that abortions might be induced in donors willing to supply such tissue. Some opponents of abortion have stated that the use of fetal tissue is acceptable if the tissues are a product of spontaneous abortion. As a practical matter the recovery and preservation of cells from the spontaneous abortion limits drastically their use as a tissue source.

A similar argument is joined with respect to the use for transplantation of healthy organs from anencephalic infants.

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Considerable publicity and debate attended a recent decision by Canadian parents who volunteered the gift of the heart from their anencephalic fetus pending delivery. This would have required life support of the anencephalic infant at birth and then a decision regarding cessation of life support to permit removal of the donor heart.

A potentially valuable outcome of the discussion precipitated by the painful problem was the development of institutional guidelines by the hospital planning to perform the infant cardiac transplantation. Their plan, as reported only in the media, is to briefly interrupt the life support at regular intervals until such time as the criteria for brain stem death are fulfilled. At that point the newborn would be declared dead and the organ(s) for transplant removed.

The scientific and clinical settings for the creation of further ethical dilemmas are rapidly expanding. Recombinant DNA technology and the ability to clone genes raise the very real possibility of introducing healthy genes in utero to the fetus known to lack them. The animal models for such intervention already exist. Using mice with an inherited anemia analogous to thalassemia in the human, researchers have introduced normal mouse globin gene copies into the chromosomes of fertilized ova from an affected parent pair. The animal developing from that treated ovum produced red cells with normal globin and is spared the otherwise heritable anemia. That animal subsequently produces normal offspring.

While application of modern biological science to the improvement of health generally is applauded, ethical sensitivities seem highest when the technology is applied to reproduction, its prevention, modification or interruption. It should be

emphasized that these concerns are by no means all religious in origin.

In this society when seemingly insoluble differences of view cannot be reconciled, redress can be sought in the courts. The courts, in turn, rely generously on precedent — where it exists — and on applicable legislation, when it has been written.

In the instance of new science and technology, as it applies to reproduction, we find ourselves in some cases without precedent and in some areas equally without legislation. Accordingly, it seems inevitable that calls for legislative definition will emerge. What topics will be targeted cannot be identified with any degree of certainty. The passions surrounding the question of abortion, pro and contra, continue to burn brightly and it would seem

“The scientific and clinical settings for the creation of further ethical dilemmas are rapidly expanding.”

likely that both further court challenges to various administrative actions and calls for new legislation will follow. Questions about the use of fetal tissue are linked closely to those of abortion and pleas for legislative action and guidance can be anticipated. It also seems likely that pressures will mount on legislative authorities to define the limits and characteristics of surrogate motherhood. It would be surprising if some of the complexities that necessarily are a part of embryo preservation and embryo transplantation do not attract legislative review. Finally, a reasonable surmise would be that yet more startling developments in human reproductive biology lie not

far ahead. If that is so, one also may be confident that ethicists, clinicians, philosophers, theologians, lawyers and legislators will have much to discourse as they seek humane and moral answers to the complex questions yet to be raised. **OSMA**

Stanley B. Troup, MD, is university professor of Medicine, Health Care and Human Values at the University of Cincinnati Medical Center, Cincinnati.

Editor's note: *Because of medicine's rapid technological advances — in all areas, not just reproduction technology, the U.S. Congress is in the process of forming a bioethical committee to advise it when such issues are brought forward on the floor. Dr. Troup has been asked to sit on that committee.*

Radiation after breast-saving cancer surgery

Nemetallah A. Ghossein, MD, of the Albert Einstein College of Medicine, New York, and colleagues studied 201 breast cancer patients treated with radiation after limited surgery and followed them for five years. The recurrence rate was 14 percent, less than half that reported for patients treated only by limited surgery.

In another group of 324 similarly-treated patients, the study says those who remained free of local recurrence or had late recurrence had significantly longer survival periods free of cancer than had disseminated to distant sites than those patients who had recurrences within five years.



Cataloging the Criticisms

An obstetrician's view

By John H. Sanders, MD

Lately, there is increasing public awareness and media attention on ethical issues. Poor moral values have been shown by high governmental figures, aspiring politicians, Wall Street brokers, religious leaders, attorneys, business leaders and union officials. All fields of medicine are being challenged, but Obstetrics and Gynecology have problems that are unique.

Contraception and abortion have always been morally troubling issues. Although the Supreme Court has legalized abortion, there still are court challenges.¹ The age of consent for teenagers for medical services including contraception is unsettled. The related issue of parental notification prior to adolescent abortion is still contested. There is debate about the propriety of using public funds to provide contraceptive counseling, medical care and

pregnancy testing for teenagers. The scope of educational services and the right of adolescents to accept them is at issue. Even in the presence of the AIDS dilemma there is disagreement about public sexual counseling and contraceptive advice.

Now, with the rapid and dramatic advances in reproductive biology, we have a whole new set of controversial issues. In vitro fertilization is no problem until one considers donor sperm, donor eggs, surrogacy and the fate of the frozen embryos. There is the question of the eligibility of the single woman or the lesbian couple for artificial insemination.

George Annas has pointed out it is now possible for "a child to be born with five distinct parents: a genetic father; a rearing father; a mother who provides the egg; the woman in whose womb the embryo gestates; and the mother who rears the child. Or again, an

embryo could be frozen for a generation, then transferred to its now-adult sister — thus becoming the daughter of its sister."² Who gets the Mother's Day card?

Disposition of the frozen embryo is another matter of concern. This situation arose recently when an American couple died in an airplane accident leaving two frozen embryos in an Australian clinic. Should they be thawed and implanted or allowed to die? Are they orphans, should they be adopted?

With the recent discovery of using transplanted aborted fetal brain tissue for the treatment of Parkinsonism come the questions of experimentation on the embryo and the harvesting of its tissues.

Amniocentesis allows sex determination for two quite different purposes: the first for preventing sex-linked hereditary disorders; the second for selecting

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the gender of the child.³ There are competing ethical claims in choosing abortion for the second reason. It is a complex issue and recognized authorities have taken both sides of this debate.

More recently there is the question of maternal vs. fetal rights. There have been lawsuits in which the physician and the court have forced pregnant women to follow medical advice for the sake of their fetuses.^{4,5} An alcoholic mother or one with drug addiction could be committed to a hospital against her will. A woman would be forced to undergo a cesarean section without giving consent.

Another area of concern is in the potential cost of medical care. Technology brings temptations along with its advantages. With the availability of ultrasound and fetal monitoring for office use, it is possible to run up astounding bills for obstetrical care if billing is on an à la carte basis rather than a global fee.

So much for reviewing some of the problems confronting us. How do we approach their solutions? There is an ethical methodology with its own jargon that can be most helpful. It involves the use of three principles. The first of these is beneficence, meaning to help the parties involved, or at least to do no harm.⁶ The second is respect for persons and includes autonomy, truth-telling and confidentiality. The third principle is justice, and concerns the equitable distribution of benefits and harms among those involved in decisions. Quite obviously these principles have to be used with different degrees of emphasis depending on the issue confronted. The use of common sense and a balanced judgment between the ends and the means, between what is good and what is right is essential. "Good moral reasoning is good reasoning

from a moral perspective."⁷ There are excellent authorities in this field who review the methodology of ethical reasoning as it applies to Ob/Gyn.^{8,9}

We have all been called upon to make ethical judgments in the course of our daily work and have usually done so with no great difficulty. These new problems will make it more challenging, but the old principles should still apply. We are part of an increasingly pluralistic society and must recognize that times, and even moral concepts, may change. We, as physicians, must be sensitive to such changes and adapt to them appropriately. OSMA

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BIBLIOGRAPHY

1. "Council on Long-Range Planning and Development of AMA With ACOG: The Future of Obstetrics and Gynecology," *JAMA*, 258:3547-53, 1987.
2. Annas, G.: *The Washington Post*, Apr. 14, 1985.
3. Fletcher, J.: "Ethics and Amniocentesis for Fetal Sex Identification," *Hastings Center Report*, 15-20, Feb., 1980.
4. Annas, G.: "Protecting the Liberty of Pregnant Patients," *N. Eng. J. Med.*, 316:1213-14, 1987.
5. Kolder, V., Gallagher, J., Parsons, M.: "Court-Ordered Obstetrical Interventions," *N. Eng. J. Med.*, 316:1192-96, 1987.
6. Mahowald, M.: "Obgynethical Issues — Present and Future," *Adv. Psychosom. Med.*, 12:1-16, 1985.
7. Ryan, K.: "Ethics in Obstetrics and Gynecology," *Am. J. Obstet. Gynec.*, 151:840-43, 1985.
8. Chervenak, F., McCullough, L.: "Perinatal Ethics: A Practical Method of Analysis of Obligations to Mother and Fetus," *Obstet. Gyn.*, 66:442-46, 1985.
9. Mahowald, M.: "Moral Quandries in Obstetrics and Gynecology," *J. Psychosom. Obstet. Gynec.*, 4:59-66, 1985.

Next month in OHIO Medicine

Next month we take another look at AIDS — specifically the clinical guidelines that have just been updated by the Ohio Department of Health. We'll also examine AIDS legislation, AIDS hospices and how the insurance industry is handling the AIDS crisis. Watch for it!

AIDS

A Clinical and Socioeconomic Look at Ohio's AIDS Dilemma

Back to School in the AIDS Classroom

By Deborah Athy

It's a long way from Chinatown and the Golden Gate Bridge to Springfield, Ohio.

To understand, then, why Carlos Andarsio, MD, took a month off from his proctology practice in Springfield to attend an AIDS seminar in San Francisco is to understand some of the motivation behind the man.

It's not the first time he's thrown caution to the wind for the sake of others — and for the sake of medicine. In 1980 he made an unusually lengthy house call to Ft. Walton Beach, Florida, to treat Cuban refugees, many of whom, as it turned out, dabbled on the shady side of the law.

For the past several years, the AIDS issue has been stacking up, on and around Dr. Andarsio's desk — in reports, policies and pamphlets — and he was again prompted to action.

He was already devoting a great deal of time in meetings around the state — at the Clark County AIDS Task Force, which he founded, the OSMA AIDS Task Force and Speakers Bureau, The Ohio Department of Insurance AIDS Advisory Committee, the Ohio Department of Health

Advisory Committee, and the Ohio Senate and House Ad Hoc Committee.

"I was spending two hours a day reading AIDS-related materials, giving presentations and talks, and attending meetings, but I had not yet established a medical relationship with anyone with AIDS," he says. "I thought I really couldn't continue speaking of AIDS if I hadn't actually treated an AIDS patient."

This helps to explain why, in the fall of 1987, he headed for the West Coast to attend the APEX program — AIDS Provider Education Experience.

Back at his home base, he sifts through what appear to be copious notes from his monthlong sojourn in San Francisco, and his recollections begin to unravel.

Back to school

The APEX experience was very demanding, Dr. Andarsio begins. It was like going back to school again. This time around, however, he had only seven other classmates — physicians from Sweden, England, San Francisco and Louisiana, and two physicians from Austria.

The APEX agenda, composed

of scientific sessions, clinical experience and field trips, is set up on an 8-to-5 schedule. The second seminar of its kind offered at San Francisco General Hospital (SFGH) to date, its purpose is to help physicians become more comfortable and knowledgeable about treating AIDS patients.

Some of Dr. Andarsio's month-in-brief included the following:

WEEK I — AIDS 101 would prove to be just the tip of the iceberg for the students. From there, seminars on Pediatrics and AIDS; IV drugs and AIDS; minorities and AIDS; visits to the San Francisco Foundation and the San Francisco Department of Health. Clinical work at the outpatient clinic, rounds at the inpatient ward, and a visit to a hospice (a 20-bed facility primarily for AIDS patients with 45-day to two-month life expectancies).

Week II — Kaposi's sarcoma (KS); neurological aspects ("More and more patients are presenting with lymphomas and neurological aspects," Dr. Andarsio notes); respiratory infections; oral manifestations; inpatient care conference.

WEEK III — Seminars on

continued on page 308



Agency Reference

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Carlos O. Andarsio, MD

The Clark County Medical Society (CCMS) has unanimously approved a resolution appointing Carlos O. Andarsio, MD, the AIDS Coordinator for the Clark County Medical Society.

The resolution noted Dr. Andarsio's involvement in AIDS organizations at the state and local levels and his overall leadership in AIDS awareness and education.

virology ("The virus is believed to be very fragile outside the body, easily killed by soap and water," he says); lymphomas; mycobacterial infections; ophthalmologic infections (such as retinitis, a dreaded complication of AIDS, Dr. Andarsio explains); induced sputum testing; women and AIDS; and legal issues. The physicians worked at the outpatient clinic.

WEEK IV — Ethics and AIDS; AIDS in the workplace; AIDS education; financial and public health issues.

Ward 86 — The Outpatient Clinic

Ward 86. Sort of has the sound of an old TV show — Route 66, Room 222.

The Outpatient Clinic is housed in an old building in front of San Francisco General Hospital. As Dr. Andarsio remembers: "It's not a new building by any means."

The clinic is set up as an AIDS and Oncology ward, although it's primarily for the treatment of AIDS patients. An inpatient ward in the main part of the hospital beds about 20 more AIDS patients.

There are usually about five to six attending physicians available, as well as a psychotherapist and a social worker.

The clinic needs that kind of staff to accommodate the number of individuals who seek treatment at Ward 86. About 18,000 patients wandered through its doors last year, a number that's expected to increase by the end of 1988, due to AIDS.

The clinic physicians treat about 60 to 80 patients per day, spending quite a bit of time on each examination, says Dr. Andarsio. Some of the physicians specialize in a particular disease of AIDS — KS, cytomegalovirus (CV) or PCP, for example. Some patients may have several AIDS-related diseases at the same time. Thus physicians often pool their knowledge, meeting in a common area of the clinic to discuss

treatment, follow-up, medication, etc.

Dr. Andarsio's firsthand acquaintance with AIDS didn't take too long after he'd arrived for the seminar. "My opening days with an attending physician I saw a patient with KS; a patient undergoing AZT treatment; an ARC patient who was an IV drug user; a patient with pneumocystis carinii pneumonia (PCP); a patient with CV; and a patient with retinitis who was almost blind," he related from his notes.

Of particular interest, he continues, is that many AIDS patients are very knowledgeable about their illnesses and treatment. They talk very frankly about their symptoms and medication, he says.

Many AIDS patients are undergoing AZT treatment. Once a scarce and coveted commodity, AZT is now very available, says Dr. Andarsio. The treatment is even being given to ARC patients and seropositive patients with no symptoms, he says.

AZT treatment is usually discontinued in a great number of patients after one year because of side effects, including nausea, confusion leukopenia, and anemia, to name a few. The verdict on AZT is probably five to 10 years away, according to Dr. Andarsio. For now, many AIDS patients are willing to take the gamble.

"The most striking experience is to see how these attending physicians identify with the patients. They not only shake hands or give a pat on the shoulder, but they act like friends."

Fear — the human factor

"I wondered before I left, would I be fearful, would I be hesitant to treat an AIDS patient? But when you are around these doctors and see how they interrelate with the patients, there is no more fear."

That is perhaps one of the most telling messages that Dr. Andarsio

“I wondered before I left, would I be fearful, would I be hesitant to treat an AIDS patient? But when you see how these doctors interrelate with the patients, there is no more fear.”

has brought back to Ohio with him, that the AIDS patient becomes just another patient in your life. “I have no fear whatsoever,” he repeats.

So in the midst of a flurry of AIDS policies and guidelines from almost every hospital, clinic and committee nationwide, Dr. Andarsio’s own advice is short and to the point: If it’s not an invasive procedure, you don’t need to glove up and wear a face mask. The bottom line is to use *appropriate* precautions for your practice, he explains.

“I’m like anyone else, I had a lot of mixed feelings before going,” he admits. “But if these doctors are treating these patients, using necessary precautions only when needed, and none have been seroconverted, then I feel pretty confident being around AIDS patients.”

Tuning in

We could learn a great deal by taking a good, hard look at the way San Francisco is coping with the AIDS situation, Dr. Andarsio recommends. “I believe their system is unique. For the past six years, they have been gaining experience the hard way.” And

it’s beginning to pay off.

Some of the successful programs in place there include: County Committee Consortium meetings held monthly at SFGH to discuss AIDS status and protocol and present clinical reports; Clinical Grand Rounds — citywide “rounds,” in which physicians visit different hospitals each month in the Bay Area; emotional and practical support groups such as the AIDS Foundation, the AIDS Health Project, and the Shanti project which offer housing, counseling and financial support to AIDS patients.

By tuning into these San Francisco programs, Ohio and other areas have an opportunity to begin building the framework for a solid AIDS network at home.

Coming home

While the AIDS dilemma is still fairly remote in his hometown, Dr. Andarsio emphasizes that his community must look to the future. “We have to ask, ‘Where are we going to put these people?’ We have to think ahead and be prepared.”

And, he continues, AIDS is not a one-physician, one-faceted disease. “This is a

multidisciplinary disease. We all have to get involved. It will be a team effort of the utmost importance.”

This means developing a good outpatient clinic, good testing and counseling protocol, skilled nurses, practical and emotional support groups, residencies, and hospices, he explains.

And Dr. Andarsio, not surprisingly, is ready to pitch in. “As a proctologist, I feel that, in conjunction with other primary care and internal medicine physicians, I can help in the treatment of these patients, addressing the emotional as well as the medical aspects of the disease. We need to assure that these patients, like all patients, feel like human beings and part of the community.”

As Dr. Andarsio shares the knowledge and ideas he’s acquired with his colleagues, perhaps we’ll also share in a commodity called *shanti* — the name of a San Francisco support group and a Sanskrit word meaning *inner peace*. As he says, “I feel pretty much in peace with myself. It was a great experience.” **OSMA**



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So What Happens if I Don't Join the AMA?

By Theodore J. Castele, MD

So what happens if you don't join the AMA? Nothing different. Life will keep going on. The current members will continue to:

- Carry forward the primary mission of the AMA which is to guard the health of the American people.
- Study carefully scientific matters like AIDS and make recommendations to all of society which will be accepted and for which great praise has been showered upon the AMA.
- Lead the country in insisting that the public's health be protected by such measures as creating a tobacco-free society by the year 2000, or insisting that seatbelts and shoulder harnesses in both the front and backseats be available and used.
- Establish guidelines or at least make a thorough study of every conceivable issue that might face medicine today, from the number of hours a physician-in-training has to work each week to the role a physician should play in witnessing the execution of a criminal.
- Participate in the accreditation process of the physician training programs throughout the country.
- Develop ethical guidelines on

how a physician should conduct his/her affairs under the most trying of medical circumstances in today's high-tech world.

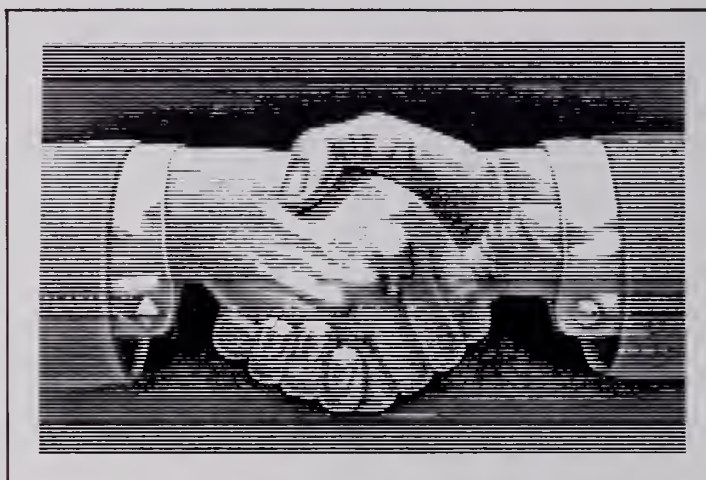
- Defend the American public against the encroachment of paraprofessionals or unscientific practitioners.
- Advise the state and federal governments on medical topics including the drafting of model legislation on a great many topics from the professional liability issue to catastrophic health insurance.
- Vigorously promote the welfare of the American people by fighting successfully to stop the same governments from passing bad legislation like mandatory assignment while at the same time promoting good legislation like Medicare reform.
- Help elect good candidates for public office, both Democratic and Republican, who will seek the advice of organized medicine in health-care issues.
- Reflect in the most democratic way possible the combined wisdom of almost 300,000 dedicated physicians in the development of policies that will affect every individual in this great country and will influence the practice of medicine throughout the world.
- Develop hundreds, no

thousands, of policy statements, pamphlets, brochures, courses, books, studies, guides, compendia, which are helpful to all physicians in their daily practice.

- Recognize the special talents of young physicians and women physicians and create special programs to seek and utilize their valuable knowledge as well as make provisions for their special problems as they practice in this modern world.
- Publish an excellent weekly newspaper containing a myriad of stories of current medical events of tremendous interest to all of us.
- Publish a weekly scientific journal, *JAMA*, which has won world acclaim and is quoted weekly on television, radio and in the print media even though it is sometimes very controversial.
- Publish a group of specialty journals which every specialist in the country in those fields (member of the AMA or not) has the option of receiving.
- Develop a great many services for members such as life insurance, disability insurance, financial planning services, practice management seminars and materials, computerized linkage with the AMA to on-line literature

continued on page 313

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OSMA Earns AMA Membership Award

D. Ross Irons, MD (middle), OSMA President, accepts the 1987 membership award from William Hotchkiss, MD (left) and Alan Nelson, MD (right) at the AMA's National Leadership Conference this past February.

searches, drug interaction data, CPT codes and more data than most of us could ever hope to use.

- Work toward getting all physicians in the country to join so that our voice will be stronger and so that we can implement more programs to further the health of our people and continue to improve the medical care system for all patients and physicians.

So, why do we want you to join? Well, for two reasons.

- You are one of us and we need you.

- Your personal involvement in the organization will add strength to our efforts. The synergism of all of us working together will greatly improve the efforts described above and will give greater credibility to the AMA. It's not just your dues we want, it's you, yourself — we want you to be an active, participating member!

And what will you get out of it?

Only one thing.

- The satisfaction of knowing that you have done everything possible to further the only mission we have as doctors: to do everything we can to promote the best health care for our patients, whether it be monitoring scientific matters, keeping regulatory agencies from jeopardizing quality of care, protecting against harmful treatment regimens, or helping the doctor practice better and more efficiently.

We want you. I sincerely hope you want to join our crusade for good medicine for the patient's benefit. Please join our ranks today. **OSMA**

Theodore J. Castele, MD, is Chairman of the Ohio Delegation to the American Medical Association.

OBITUARIES

HARRY H. BOSS, MD, Cincinnati; Medizinische Akademie im Dusseldorf, Dusseldorf, Nordrhein-Westfalen Germany, 1950; age 66; died November 27, 1987; member OSMA and AMA.

PAUL E. CHEEK, MD, Oak View, CA; University of Louisville School of Medicine, Louisville, KY, 1943; age 69; died January 11, 1988; member OSMA and AMA.

F. PAUL DUFFY, MD, Cincinnati; University of Cincinnati College of Medicine, 1943; age 70; died January 1, 1988; member OSMA and AMA.

JAMES L. FISHER, MD, Youngstown; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1918; age 92; died December 24, 1987; member OSMA and AMA.

PAUL A. HARRIS, SR., MD, Dayton; Meharry Medical College, Nashville, TN, 1959; age 56; died January 2, 1988; member OSMA and AMA.

MAX P. KANTER, MD, Columbus; Ohio State University College of Medicine, 1922; age 89; died December 23, 1987; member OSMA and AMA.

PAUL G. LENHART, MD, Arcanum; University of Cincinnati College of Medicine, 1934; age 84; died November 25, 1987; member OSMA and AMA.

DALE H. MAGLEBY, MD, Columbus; George Washington University School of Medicine, Washington, DC, 1953; age 64; died December 15, 1987; member OSMA and AMA.

WILLIAM MOLNAR, MD, Columbus; Orvosi Fakultás Tudományegyetem, Budapest, Hungary, 1942; age 72; died December 7, 1987; member OSMA and AMA.

ARTHUR H. SPREEN, MD, Cincinnati; University of Cincinnati College of Medicine, 1937; age 75; died December 8, 1987; member OSMA and AMA.

County Medical Societies . . . continued

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OTTAWA: Guillermo Crisologo, M.D., President, 620 Jefferson St., Port Clinton, 43452-2413; Ih-Foo Lin, M.D., Secretary-Treasurer, 1803 Concord Circle, Port Clinton 43452-2935. Second Thursday during football season; otherwise, Friday after second Thursday; no summer meetings.

PAULDING: Don K. Snyder, M.D., President, Box 57, Payne 45880-0057; Kirkwood A. Pritchard, M.D., Secretary-Treasurer, 119 S. Main St., Paulding 45879-1409. Third Monday.

PUTNAM: Anna M. Horstman, M.D., President, Box 256, Kalida 45853-0256; David D. Houston, M.D., Secretary-Treasurer, 5560 S.R. 12, Box 299, Pandora 45877-0299. First Tuesday.

SANDUSKY: Mary E. Verdon, M.D., President, 605 Third Ave., Suite B, Fremont 43420-3269; Patricia Lindholm, M.D., Secretary-Treasurer, 42 Glendale Ave., Fremont 43420-3155. Third Wednesday.

WILLIAMS: Thomas M. Coon, M.D., President, 507 Newdale Dr., Bryan 43506-1930; Richard L. Hess, M.D., Secretary-Treasurer, 442 W. High St., Bryan 43506-1616; Rebecca Cape, Executive Secretary; Bryan Medical Group, 442 W. High St., Bryan 43506, 419/636-4517. Monday, Wednesday, every other Friday. Third Tuesday, September, November, January, March and May.

***WOOD:** Robert G. Neville, M.D., President, 960 W. Wooster St., Suite 207, Bowling Green 43402-2646; Jose Guerra, Jr., M.D., Secretary-Treasurer, 727 Rosalind Dr., Bowling Green 43402. Second Thursday.

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ASHTABULA: David A. Floering, M.D., President, 2420 Lake Ave., Ashtabula 44004-4954; Hector T. Abueg, M.D., Secretary-Treasurer, 244 Parrish Blvd., Conneaut 44030-2031; Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, 216/997-6640. Second Tuesday.

***CUYAHOGA:** Wilma F. Bergfeld, M.D., President, Cleveland Clinic, Desk A-61, 9500 Euclid Ave., Cleveland 44106-4712; O. David Solomon, M.D., Secretary-Treasurer, 26900 Cedar Rd., #310, Cleveland 44122-1148; George D. Reitz, Executive Vice President, 11001 Cedar Ave., Cleveland 44106, 216/229-2200. Board of Directors second Tuesday.

GEAUGA: Mansukhlal Domadia, M.D., President, 14577 E. Park St., Burton 44021; Bruce T. Bucklan, M.D., Secretary-Treasurer, P.O. Box 249, Chardon 44024; Margaret Pace, Executive Secretary, Geauga Hospital, P.O. Box 249, Chardon 44024, 216/286-6131. Second Thursday, February, April/May, September and November.

LAKE: Mahmood Pazirandeh, M.D., President, 33350 Shaker Blvd., Pepper Pike 44124; Janis Hedin, M.D., Secretary-Treasurer, 54 S. State St., #201, Painesville 44077-3423; Janice A. Vargo, Executive Secretary, 5900 Dewey Rd., Madison 44057, 216/942-9135. February, May, September and November.

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Councilor: *J. James Anderson*,

M.D., 5204 Mahoning Ave., Suite 103, Youngstown 44515.

COLUMBIANA: Paul W. Lim, M.D., President, 1448 Homestead Dr., East Liverpool 43920-9450; Karl Getzinger, M.D., Secretary-Treasurer, 356 E. Lincoln Way, Lisbon 44432-1443; Pearl Koenreich, Executive Secretary, 530 Hawley Ave., Salem 44460, 216/337-8859. Third Tuesday, September through May except December.

MAHONING: Hai-Shiuh Wang, M.D., President, 10 Dutton Dr., Youngstown 44502-1818; Kimbroe J. Carter, M.D., Secretary, St. Elizabeth Hospital, P.O. Box 1790, Youngstown 44501; Eleanor Pershing, Executive Director, 1005 Belmont Ave., #245, Youngstown 44504, 216/747-4956. Third Tuesday, January, March, May, September, November and December.

STARK: Robert C. Erickson II, M.D., President, 2606 Wales Rd., N.W., Massillon 44646-2385; Krishna Agarwala, M.D., Secretary-Treasurer, 4168 Holiday St., N.W., Canton 44718-2532; Nancy L. Adams, Executive Director, 4150 Belden Village St., N.W., Canton 44718, 216/492-3333. First Thursday, September through June.

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Councilor: *Nermin D. Lavapies*, M.D., 1220 Hughes Ave., Martins Ferry 43935-1935.

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43935-1935. Third Tuesday, February through April and September through December.

CARROLL: Nan M. Bissell, M.D., President, 450 S. Lisbon St., Box 338, Carrollton 44615-0338; Donald P. Wingard, D.O., Secretary-Treasurer, P.O. Box 265, Carrollton 44615-0265. Third Tuesday.

COSHOCTON: Gary J. Carver, M.D., President, 904 Green Dr., Coshocton 43812-2454; Ronald Dillow, M.D., Secretary-Treasurer, 1849 Hillcrest Dr., Coshocton 43812-2729. Second Tuesday.

HARRISON: Isam Tabbah, M.D., President, Dept. of General Surgery, R.D. #1, Cadiz 43907; Remigio C. Rubiano, M.D., Secretary-Treasurer, Harrison Community Hospital, 951 E. Main St., Cadiz 43907. Second Tuesday.

JEFFERSON: Patrick Macedonia, M.D., President, One Ross Park, Steubenville 43952; Narendra Patel, M.D., Secretary-Treasurer, P.O. Box 2076, Wintersville 43952. First Tuesday, August through May.

MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793-1023; Linda K. Loughman, M.D., Secretary-Treasurer, Monroe County Clinic, Route 3, Woodsfield 43793-9802. Second Wednesday quarterly.

TUSCARAWAS: Dale R. Kollman, M.D., President, P.O. Box 341, Tuscarawas 44682-0341; Timothy P. Desiato, M.D., Secretary-Treasurer, 1716 Cross St., Dover 44622-1043. Doris Ferguson, Executive Secretary, Union Hospital, 659 Boulevard, Dover 44622, 216/343-3311. Second Wednesday.

EIGHTH DISTRICT

Councilor: *John F. Kroner, Jr.*, M.D., 444 W. Union St., Box 708, Athens 45701.

ATHENS: Gerald W. Noga, M.D., President, 5150 Radford Rd., Athens 45701; John D. Cunningham, M.D., Secretary-Treasurer, 18 Hooper St., Athens 45701. Second Tuesday, March,

June, September and December.

FAIRFIELD: Thomas R. Vajen, M.D., President, 1030 Woodlane Dr., N.E., Lancaster 43130-1351; John Lloyd, M.D., Secretary-Treasurer, 600 Pleasantville Rd., Lancaster 43130-3325; Jane E. Patterson, Executive Secretary, c/o David H. Sheidler, M.D., 1500 E. Main St., Lancaster 43130, 614/654-0059. Second Tuesday.

GUERNSEY: Janet Brockwell, M.D., President, 65555 Matthews Rd., Route 1, Cambridge 43725-9801; Stephen W. Stansbury, M.D., Secretary-Treasurer, 1337 N. Clark St., P.O. Box 357, Cambridge 43725-0357. First Tuesday alternating months starting February.

LICKING: Carl Waggoner, M.D., President, 1850 Cedar Circle, Heath 43056-1719; Alex D. Juan, M.D., Secretary-Treasurer, 1406 Dickerson St., Newark 43055; Kitty Martin, Executive Secretary, Licking Memorial Hospital, 1320 W. Main St., Newark 43055, 614/366-0533. Fourth Tuesday.

MORGAN: No active county medical society.

MUSKINGUM: Thomas N. Ruggles, M.D., President, 2900 Ash Meadows Blvd., Zanesville 43701-9081; Vicki Whitacre, M.D., Secretary-Treasurer, 2435 Dunzweiler Dr., Zanesville 43701-9624. First Tuesday, September through May.

NOBLE: Frederick M. Cox, M.D., President and Secretary-Treasurer, 523 Main St., P.O. Box 330, Caldwell 43724-1324.

PERRY: Stephen C. Ulrich, M.D., President, 1625 Airport Rd., P.O. Box 109, New Lexington 43764-0109; William D. Fiorini, M.D., Secretary-Treasurer, 313 North Dr., P.O. Box 430, Somerset 43783-0043. Meet four times yearly.

WASHINGTON: David L. Wirtz, M.D., President, Dye St., P.O. Box 188, Newport 45768; William C. Grosel, M.D., Secretary-Treasurer, 27 Tecumseh Dr., Marietta 45750-9630. Second

Wednesday, September through May.

NINTH DISTRICT

Councilor: *Thomas P. Price, Jr.*, M.D., Holzer Clinic, Ltd., 385 Jackson Pike, Gallipolis 45631.

GALLIA: T. Wayne Munro, M.D., President, Holzer Clinic, EMR, Gallipolis 45631-9833; James R. Magnussen, M.D., Secretary-Treasurer, Holzer Clinic, Ltd., 385 Jackson Pike, P.O. Box 344, Gallipolis 45631-0344. Meet quarterly.

HOCKING: Steven W. Walter, M.D., President, 751 S.R. 664 N., Box 918, Logan 43138; Rosario M. Labrador, M.D., Secretary-Treasurer, P.O. Box 0920, Logan 43138. Meet three times yearly.

JACKSON: Patrick B. Ball, D.O., President, 350 Charlotte Ave., Oak Hill 45656-1326; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640-1931. Meetings when called.

LAWRENCE: Harold Dyer, D.O., President, 408 Washington St., Ironton 45638; A. Burton Payne, M.D., Secretary-Treasurer, 411 Center St., Ironton 45638-1506. Fourth Thursday.

MEIGS: E.S. Villanueva, M.D., President, 505 Mulberry Heights, Pomeroy 45769-9573; Wilma A. Mansfield, M.D., Secretary-Treasurer, P.O. Box 709, Pomeroy 45769-0709. Meetings when called.

PIKE: Kenneth A. Wilkinson, M.D., President, 100 Hilltop Rd., Waverly 45690; Shashikant B. Patel, M.D., Secretary-Treasurer, 621 Fifth St., Waverly 45690-1505. Second Monday.

SCIOTO: Ronald E. Arrick, M.D., President, Mercy Medical Plaza, Bldg. C, Suite 3-A, 1825 Oakland Ave., Portsmouth 45662; Suzann M. Bonzo, M.D., Secretary-Treasurer, 1725 27th St., Suite 1-B, Portsmouth 45662-2654; Ann Borden, Executive Secretary, 1805 27th St., Portsmouth 45662-2640, 614/354-5315. Second Tuesday, September through June, except December meeting is second

continued on page 325

A group of five healthcare professionals are gathered around a table, all reading 'Postgraduate Medicine' journals. In the background, a man in a blue surgical cap and green scrubs looks on. In the foreground, an older man with a mustache and glasses reads intently. Next to him, a woman in a white lab coat eats an apple while looking at her journal. To her right, a young man in a plaid shirt rests his chin on his hand, also reading. A woman in a blue lab coat stands behind him, holding her journal. The scene is dimly lit, with the journals providing a source of light. The journal in the bottom left corner has the title 'Postgraduate Medicine' and the subtitle 'The Journal of Continuing Medical Education for the Primary Care Physician' clearly visible.



You don't have time to waste on medical writing that is cluttered with complicated statistics and data. Depend on *Postgraduate Medicine* to provide you with clearly written, well-illustrated articles on matters of practical importance in your daily life.

Minutes From the 11th Interim Assembly Meeting

*December 4-6, 1987
Atlanta, Georgia*

The 11th interim meeting of the American Medical Association's Resident Physicians Section (AMA-RPS) was a meeting of active business and often heated debate concerning many issues including resident work hours, stress during residency, GFSL Loan repayments and resident AIDS exposure.

The meeting opened with Ross Rubin, JD, the director of the AMA's Department of Federal Legislation, updating the section on pertinent federal and state legislation. He noted:

The federal and state legislative arena is and will continue to act "responsibly" in taxing and spending in an effort to continue to keep worldwide respect after the stock market crash. The AMA expects that all legislation will be directed toward this goal. In other words, there will be a large amount of volatility to avoid the Gramm-Rudman mandatory cuts. To this end, the bad news:

- All discretionary health accounts: NIH, CDC, AIDS Research . . . have been cut 8.35% until Congress meets the budget targets.

- Medicare cuts 2.34% immediately both at the DRG and physician reimbursement levels, thus decreasing the ability to meet education needs of house staff.

- A reduction from 8.9% to 6.7% of income for resident teaching. We have done far too well under DRGs than we were suppose to.

- A proposal to cut Medicare FMG funding completely in the near future (Minn.). This would hurt greatly many public hospitals in major cities and in the less popular specialties. This was presented to Congress in December 1987. Further details were lacking.

- There has been no significant effort to tax student loans. However, there has also been no real enthusiasm for making our loan interest deductible.

- State issues have been particularly volatile. **Resident physician working hours and stresses** are a major nationwide issue. The AMA has been very active in New York, Pennsylvania and California providing testimony. The major consensus, if there is one, centers around the wishes of physicians to clean up their own shop without government regulation or oppressive involvement.

The AMA-RPS engaged in very active and heated debate, finally passing **Resolution M (I-87)** which was later adopted with slight revision by the AMA House. A partial summary of the major conclusions from the Resident Physicians Section:

1. Residency Review Committees (RRCs) should develop guidelines . . . with a **specific focus on weekly or continuous work hours, emphasizing adequate time off** for each branch of medicine under its review. (See enclosure on average

continued on page 318

Minutes From the 11th Interim Meeting . . . *continued*

resident hours worked per specialty.)

2. **Residents must not bear the financial responsibility** for increased costs . . . of any changes in the system.

3. **The educational mission must not be compromised** by a routine reliance on . . . service.

4. Residents must be provided with **adequate compensation and benefits** . . .

5. . . . **Back-up should be provided so that chronic fatigue, excessive workloads, stress and sleep deprivation do not compromise a resident's ability** to provide high quality patient care and to achieve educational objectives.

6. **Flexible, alternative and part-time scheduling options should be routinely available** . . .

Additional conclusions addressed **unsupervised medical care, quality of care and a request to study the problems.**

Some other successes:

- Mandatory assignment under Medicare (again from Donnelly, Mass.) — VETOED.

- DRGs for all physician

services (ie. the "RAP" group of Radiology, Anesthesiology and Pathology) — VETOED.

- Medicare Catastrophic Insurance — initially a fast track, easy pushover item, has passed the House and Senate but has not yet been signed into law. Basically the bill provides only "Medigap" coverage but does not address such problems as long-term facilities and care.

- Drug dispensing by physicians (Weidem, Ore.), intended to block the physician from dispensing any drugs in the office. The bill is now in legislative limbo.

- Smokers: The Department of Transportation sponsored a bill, passed after only nine hours of debate, that will prohibit smoking on flights less than two hours long. The House is seeking to change this slightly.

Many resident physician issues were actively debated, including resolutions to:

- Assess the impact of AIDS on residency training

- Study the impact of sexually-oriented advertising

- Support preventive medicine residencies

- Remove tobacco products from pharmacies

The meeting was adjourned on December 6th after the completion of old and new business with numerous resolutions sent to the AMA House. Submitted to governing council and members.

Louis A. Cannon, MD

Chairperson-Elect

Ohio State Medical Association

Resident Physicians Section

Delegate to AMA/Resident

Physicians Section

Quotes of Note

"A fanatic is one who can't change his mind and won't change the subject."

— *Sir Winston Churchill*

**Total Hours Worked per Week
by Program Specialty***
All

Program Specialty	All			1st Year		
	Mean	Median	90th Percentile	Mean	Median	90th Percentile
Family Practice	70.6	69.0	101.0	82.3	83.0	110.0
Internal Medicine	74.6	73.0	107.0	90.3	93.0	116.9
Surgery	87.0	87.0	122.0	98.0	102.0	125.0
Pediatrics	79.2	80.0	107.2	93.6	94.0	120.0
Obstetrics/Gynecology	89.1	89.0	117.3	93.9	89.5	120.2
Radiology	50.1	52.0	71.0	51.0	53.0	71.2
Psychiatry	52.6	50.0	74.7	66.5	67.0	96.0
Anesthesiology	76.0	75.0	102.0	81.4	82.0	121.2
Pathology	48.0	50.0	75.1	54.2	57.0	78.4
Other	70.6	69.0	102.0	87.0	87.0	112.0

Source: 1987 Survey of Resident Physicians, AMA Center for Health Policy Research.

* Excludes moonlighting activities.

Definitions: 1) Mean = arithmetic average; 2) Median = the midpoint of the distribution, i.e., half of all respondents reported a value less than the median; and 3) 90th percentile = 90 percent of respondents reported a value less than the 90th percentile.

Preventative Medicine To Protect Your Financial Fitness

*By John E. Sestina
SMB Financial Planning Inc.*

During the past 20 years spent advising business people and other professionals, I have found that everyone faces the same obstacles when it comes to reaching their financial goals — taxes, inflation, death, disability, and lack of a plan and/or the time to update it.

Schedule regular “fiscal exams.” Lack of time to plan is critical for all of us because of the many demands on our time: maintaining a job, continuing our education, reading to stay current, family and recreation. The most productive way to use your limited financial planning time is to schedule “fiscal exams” for yourself and structure them to your particular needs and goals, starting with the preparation of an updated balance sheet.

The balance sheet is your financial X-ray and I recommend

using it at least twice a year: in January to review the result of the past year and to plan your goals, tax and investment strategies for the coming year; and once again in June to monitor your progress and make adjustments. It is crucial that your spouse and your professional advisers be involved in these exams to ensure that every one of your knowledgeable “partners” has the opportunity to contribute information and help you evaluate it.

This appointment with yourself is just as important as an annual physical exam and should be thought of as “non-cancellable.” After all, your financial health is at stake.

Social pressures and “hot water.” American society puts tremendous pressure on most of us to project the image of success — an expensive new car every year, sumptuous homes, designer

clothes, children in the most prestigious schools, etc.

It is sadly true that most Americans spend more than they earn. In fact, many professionals I hear about very often end up in “hot water” of deficit financing because of these social pressures, forgetting that only the government is allowed this luxury.

Find out exactly how much is really being spent by completing the sample Cash Flow Worksheet. It will give you a much better handle to develop a realistic goal for spending, retirement, education and other short or long-term needs. It will also serve as a guide toward appropriate savings and investment goals.

“Sex appeal” is for movies, not investments. Most of us are naturally attracted by the idea of “inside information” on investments with exotic “sex appeal” such as gems, cattle and

CASH FLOW PLANNING

CASH FLOW WORKSHEET SAMPLE

	Mar	Apr	May	Jun	Jul
INCOME					
1 Cash Available	5,000				
2 Salary	6,000	6,000	6,000	6,000	6,000
3 Self Employment Net Inc					
4 Investment Income					
5 TOTAL INCOME	11,000	6,000	6,000	6,000	6,000
EXPENSES					
6 Taxes — Personal Prpty	0	0	0	0	0
7 Taxes — real estate	0	0	0	0	0
8 Home Maintenance	200	200	200	200	200
9 Food	100	100	100	100	100
10 Household Expenses	500	500	500	500	500
11 Medical/Dental	150	50	250	150	50
12 Clothes	700	500	500	500	500
13 Charitable Contributions	200	200	200	200	200
14 Auto — gas/repairs	200	200	200	200	200
15 Home Mortgage #1	1,400	1,400	1,400	1,400	1,400
16 Telephone — home	100	100	100	100	100
17 Electric — home	400	200	200	200	200
18 Water — home	65	65	150	150	150
19 Cable — home	48	48	48	48	48
20 Business Expense	400	400	100	400	100
21 Education	0	0	0	0	0
22 Insurance — life	0	1,500	0	0	1,500
23 Insurance — home	0	0	0	0	0
24 Insurance — automobile	200	200	200	200	200
25 Insurance — personal umb	0	0	0	0	0
26 Gifts	50	50	50	50	50
27 Vacations	0	0	0	0	2,000
28 Miscellaneous	200	200	200	200	200
29 Lessons	245	245	245	0	0
30 Camp	0	1,000	0	0	0
31 Bank #1	239	239	239	239	239
32 Bank #2	300	300	300	300	300
33 Bank #3	150	150	150	150	150
34 Bank #4	200	200	200	200	200
35 TOTAL EXPENSES	6,047	8,047	5,532	5,487	8,587
36 NET INCOME	4,953	(2,047)	468	513	(2,587)
37 CUMULATIVE SURPLUS	4,953	2,906	3,374	3,887	1,300

oil well leases.

This is where individuals are most likely to get burned. Most of us learn very little in school about evaluating business risks, so we become easy prey for anyone selling an impressive “deal” whose chances for real economic gain are on a par with the Las Vegas roulette tables.

I advise my clients to “learn to walk before you try to fly” by

scheduling sound investments according to the level of risk you can afford. The Investment Triangle was developed to guide you in making decisions relative to how much of your investment dollar should be spent at each level of risk and how much return you should expect.

By all means, go ahead and gamble if you like . . . but do it with your eyes open to the risks

and build a good foundation to cushion your losses.

Remember that YOU are the employer. When hiring financial advisers, your chief responsibility to yourself is to understand their advice so it can really help you. One new client recently lamented to me, “I really didn’t ask many questions because I didn’t want to show my ignorance.”

You can afford no less than the

Aug	Sep	Oct	Nov	Dec	Jan	Feb	TOTALS
6,000	6,000	6,000	6,000	6,000	6,000	6,000	72,000
							0
6,000	6,000	6,000	6,000	6,000	6,000	6,000	72,000
0	0	0	0	3,000	0	0	3,000
0	0	0	0	4,000	0	0	4,000
200	200	200	200	200	200	200	2,400
100	100	100	100	100	100	100	1,200
500	500	500	500	500	500	500	6,000
50	150	50	50	150	50	50	1,200
1,500	500	500	1,500	500	500	500	8,200
200	200	200	200	200	200	200	2,400
200	200	200	200	200	200	200	2,400
1,400	1,400	1,400	1,400	1,400	1,400	1,400	16,800
100	100	100	100	100	100	100	1,200
200	250	300	400	400	500	400	3,650
100	100	100	65	65	65	65	1,140
48	48	48	48	48	48	48	576
100	400	100	100	400	100	100	2,700
0	0	0	0	0	0	0	0
0	0	1,500	0	0	1,500	0	6,000
0	0	0	0	0	0	0	0
200	200	200	200	200	200	200	2,400
0	0	0	0	0	0	0	0
50	50	50	50	50	50	50	600
0	0	0	0	0	0	1,500	3,500
200	200	200	200	200	200	200	2,400
0	245	245	245	245	245	245	2,205
0	0	0	0	0	0	0	1,000
239	239	239	239	239	239	239	2,868
300	300	300	300	300	300	300	3,600
150	150	150	150	150	150	150	1,800
200	200	200	200	200	200	200	2,400
6,037	5,732	6,882	6,447	12,847	7,047	6,947	85,639
(37)	268	(882)	(447)	(6,847)	(1,047)	(947)	(13,639)
1,263	1,531	649	202	(6,645)	(7,692)	(8,639)	

very best financial advice because your training is in your vocation — not law or accounting — and you have every right to ask until you understand.

Let your advisers educate you — in fact, insist upon it. Do not permit your advisers to speak their language — whether it is legalese, accountantese or insurancese. If they speak only a language you can understand, it makes for a

more productive relationship and greater financial return.

Beware of the “tax shelter carrot.” Taxes are one of life’s most painful realities to all of us. It is easy to understand why many used to jump at the chance of an investment that offers, say \$8 in tax deductions for every \$1 invested. Unfortunately, most people who tried that forgot the purpose of any investment is to

provide genuine bottom-line economic gain. Perhaps you will be more realistic with essentially the elimination of tax shelters in the new tax law. But now there will be other tempting “deals” with dramatic promises that might catch your fancy.

Protect yourself by asking a lot of questions when an investment salesman presents a “golden” or “once in a lifetime” opportunity

BALANCE SHEET

ASSETS	Date	ASSETS	Date
Current assets		Automobiles	_____
Cash on hand	_____	Home furnishings	_____
Checking accounts	_____	Other personal property	_____
Money Market accounts	_____	Non-investment collection	_____
Savings accounts	_____	Other vehicles & equip	_____
Treasury bills	_____	Other non-earning assets	_____
Life Ins cash value	_____	Total personal/non-earning assets	_____
Escrow account	_____		
Short-term receivables	_____	Business assets	
Other current assets	_____	Cash account/business	_____
Total current assets	_____	Checking account/bus	_____
Marketable investments		Accounts receivable/bus	_____
Common stocks	_____	Short-term investment/bus	_____
Preferred stocks	_____	Deposits/bus	_____
Treasury bonds	_____	Inventory/bus	_____
Corporate bonds	_____	Land/bus	_____
Municipal bonds	_____	Buildings/bus	_____
Unit investment trust	_____	Furniture & fixtures/bus	_____
R.E.I.T. shares	_____	Mfg equipment/bus	_____
Mutual funds	_____	Transport equip/bus	_____
Traded stock options	_____	Office equipment/bus	_____
Warrants	_____	Other fixed assets/bus	_____
Futures contracts	_____	Other assets/bus	_____
Other marketable invest	_____	Total business assets	_____
Total marketable investments	_____		
Long-term investments		Unclassified assets	
Real estate	_____	Unclassified assets	_____
Farming interests	_____	Total unclassified assets	_____
Oil & Gas investments	_____		
Tax shelters	_____	Total assets	_____
Leasing investments	_____		
R & D ventures	_____	Current liabilities	
Venture Capital investment	_____	Credit cards	
Annuities	_____	Demand notes	
Deposits	_____	Margin accounts	
Long-term receivables	_____	Other	
Mortgage receivables	_____	Long-term liabilities	
Int-free loan receivable	_____	Home mortgage	_____
Stock purchase plan	_____	Home improvement loan	_____
Executive stock options	_____	Other real estate mtge	_____
Investment collections	_____	Auto loans	_____
Precious metals	_____	Student loan	_____
Mineral royalties	_____	Loan on life insurance	_____
Closely-held businesses	_____	Investment liabilities	_____
Other long-term assests	_____	Int-free loan payable	_____
Total long-term assets	_____	Other long-term liab	_____
Retirement/deferred assets		Total long-term liabilities	_____
IRA	_____		
Keogh account	_____	Business liabilities	
Retirement plan	_____	Accounts payable/bus	_____
Deferred compensat'n plan	_____	Accrued expenses/bus	_____
Other retirement plans	_____	Prepaid orders/bus	_____
Total retirement/deferred assets	_____	Employment taxes/bus	_____
Trust and estate assets		Accrued FICA tax/bus	_____
Trust assets	_____	Other payroll taxes/bus	_____
Estate assets	_____	Long-term loans/bus	_____
Total trust and estate assets	_____	Other liabilities/bus	_____
Personal/non-earning assets		Total business liabilities	_____
Residence	_____		
Vacation property	_____	Unclassified liabilities	
		Unclassified liabilities	_____
		Total unclassified liabilities	_____
		Total liabilities	_____
		Net worth (total assets — total liabilities)	_____

to you, especially:

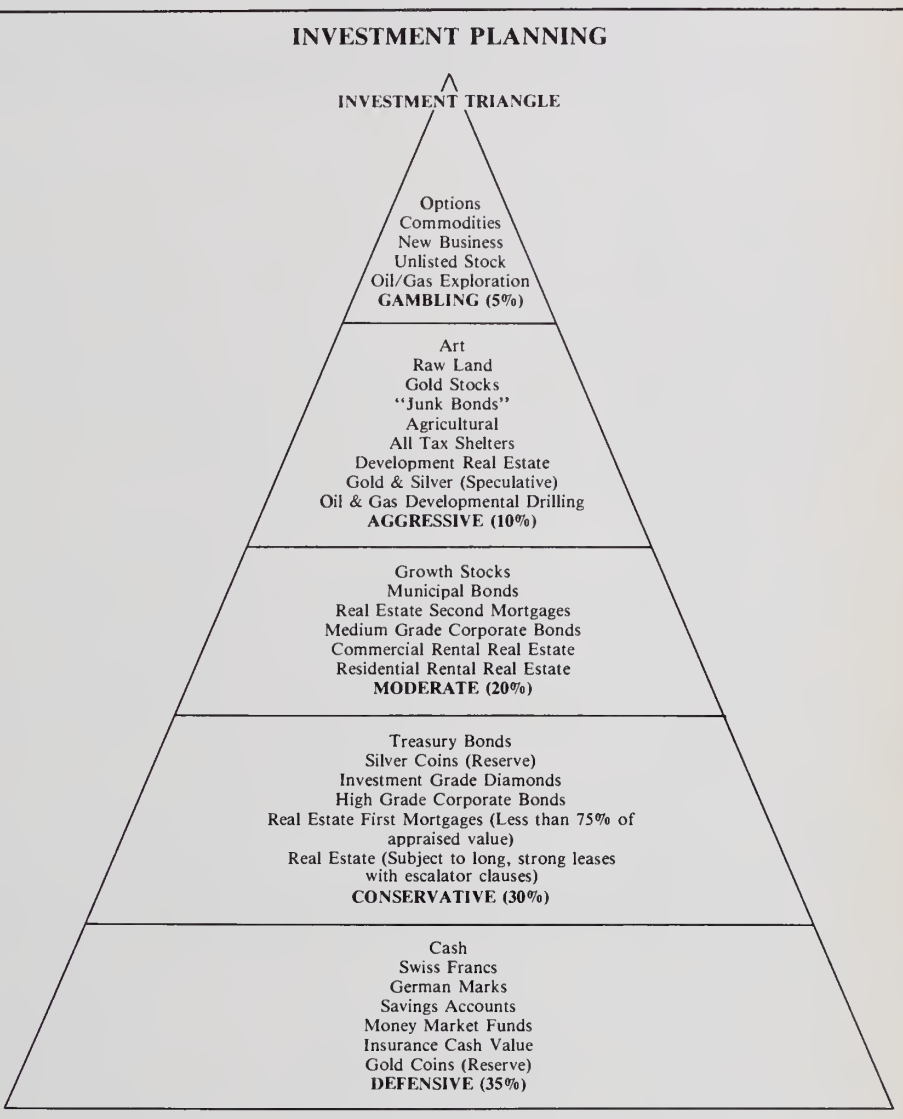
- Is this investment an economically sound one (i.e. benefit-producing) even without any unusual tax aspects?
- What are MY goals for this investment — sheltering income, producing more bottom-line spendable cash, or producing a rate of return that is acceptable to me?
- Has the salesman given me all the information I need to evaluate costs against real benefits?
- If it's so good, why did you bring it to me?

Let financial tools work FOR you. Many of us are in a unique position to use our personal and business financial tools to produce income and tax advantages. Unfortunately, many of the people I know resist using these tools because they do not understand them.

Consider the example of incorporating a professional practice. This is usually a very smart tax-saving move for entrepreneurs above a certain income level. The objection I hear most frequently is, "Now that I can put as much in a Keogh plan, does it still make sense to incorporate?"

A financial tool like incorporation has several advantages:

- It is more conducive to sound business practices and record-keeping than a sole proprietorship.
 - It segregates personal and business finances to give you a more realistic picture of actual financial health.
 - It offers the tax planning flexibility of income splitting more than just through a pension plan.
- Other tools like pensions, IRA's etc. still work. It's knowing how to use them that gives you the



long-term benefit.

The bottom line for your financial fitness is to learn and get involved. The time spent does not have to be inordinate, as long as you concentrate on what questions to ask and develop the tools that will work most productively for you. The time will be an investment with a very high rate of return because no one else cares as much about your finances as

you do. **OSMA**

John E. Sestina is a vice president with SMB FINANCIAL PLANNING, Inc., a member of the PICO Financial Services Group which provides specialized financial planning services to physicians and other professional individuals and corporations on a fee-only arrangement.

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County Medical Societies . . . continued

Friday and February's is second Thursday.

VINTON: No active county medical society.

TENTH DISTRICT

Councilor: *H. William Porterfield, M.D.*, Physicians Health Plan, 3650 Olentangy River Rd., Columbus 43214.

DELAWARE: David S. Smith, Jr., M.D., President, 1201 U.S. Route 23 N., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 141 S. Main St., Prospect 43342-9569. Third Tuesday, March, June, September and December.

FAYETTE: Cheng-Haw Hung, M.D., President, 1049 Washington Ave., Washington C.H. 43160-2057; Robert A. Heiny, M.D., Secretary, 616 Willard St., P.O. Box 457, Washington C.H. 43160-0457. Second Friday.

***FRANKLIN:** Claire V. Wolfe, M.D., President, 5521 Indian Hill Rd., Dublin 43017-9709; Ronald E. Kendrick, M.D., Secretary-Treasurer, 911 Stoney Creek Rd., Worthington 43085-3454; James S. Imboden, Executive Director, 525 Metro Place N., Suite 440, Dublin 43017, 614/766-6221. February, August, September and October.

***KNOX:** Robert Rodstrom, M.D., President, 812 Coshocton Ave., Mt. Vernon 43050-1947; Terry P. Barber, M.D., Secretary-Treasurer, 136 Mill St., P.O. Box 483, Utica 43080-0483. First Wednesday.

MADISON: C. Terrill Hay, M.D., President, 214 Elm St., London 43140-1184; Peter Dashko, D.O., Secretary-Treasurer, 9 E. Second St., London 43140. Second Wednesday, quarterly.

MORROW: D. James Hickson, M.D., President, 712 Baker St., Mt. Gilead 43338-1082; Parviz Meftah, M.D., Secretary-Treasurer, 152 W. High St., Mt. Gilead 43338-1214. First Tuesday.

PICKAWAY: Faryar Moshtaghi, D.O., President, 401 E. Main St., Circleville

43113-1843; Gary L. Gillen, M.D., Secretary-Treasurer, 111 Island Rd., Circleville 43113-9576. Second Tuesday, September through June.

ROSS: Richard C. Rooney, M.D., President, P.O. Box 904, Station A, Chillicothe 45601; C. Mitchell Fields, M.D., Secretary-Treasurer, 4457 S.R. 159, Chillicothe 45601-8620. First Thursday, September through June.

UNION: Michael J. Conrad, M.D., President, 498 London Ave., Suite H, Marysville 43040; Malcolm MacIvor, M.D., Secretary-Treasurer, 110 N. Court St., Marysville 43040. Meet quarterly.

ELEVENTH DISTRICT

Councilor: *Charles G. Adams, M.D.*, 5896 Liberty Ave., Vermilion 44089.

ASHLAND: Mohinder K. Gupta, M.D., President, 21 Sugarbush Ct., Route 250 E., Ashland 44805; Roger O. Snyder, M.D., Secretary-Treasurer, 350 Hillcrest Ave., Ashland 44805. First Tuesday.

ERIE: Thomas B. Williamson, M.D., President, 212 Cleveland Rd., Huron 44839; Raj N. Ravindra, M.D., Secretary, P.O. Box 2274, Sandusky 44870-2274; Barbara Wolfert, Executive Secretary, 2710 Scheid Rd., Huron 44839, 419/433-3097. Second Tuesday.

HOLMES: Maurice E. Mullet, M.D., President, W. Main St., Berlin 44610; Daniel J. Miller, M.D., Secretary-Treasurer, P.O. Box 143, Walnut Creek 44687-0143. Second Monday.

HURON: Pura G. Garin-Vargas, M.D., President, 38 Executive Dr., Norwalk 44857-2421; Narinder N. Khosla, M.D., Secretary-Treasurer, 4455 County Rd. 175, P.O. Box 37, Clyde 43410-0037. Second Wednesday, February, April, June, October and December.

LORAIN: Romeo S. Miclat, M.D., President, 824 E. Broad

St., Elyria 44035-6559; William M. Jantsch, M.D., Secretary-Treasurer, 4898 Oakhill Blvd., Lorain 44053-1918; Shirley Dalton, Executive Director, 1875 N. Ridge Rd. E., Suite E, Lorain 44055, 216/277-9009. Second Tuesday.

MEDINA: Bijay K. Jayaswal, M.D., President, 3647 Medina Rd., Medina 44256-9632; Thomas L. Tulisaiak, M.D., Secretary-Treasurer, 1839 Pearl Rd., Suite A-202, Brunswick 44212-3297; Shelley Dunkle, Executive Secretary, MEDCO, 696 E. Washington St., Suite 2-B, Medina 44256, 216/725-5331. Third Thursday, October through May except December.

RICHLAND: Keith C. Bogart, M.D., President, 222 Marion Ave., Mansfield 44903-2138; Richard L. Clark, M.D., Secretary-Treasurer, 102 Auburn Ave., Lower Level Suite, Shelby 44875-1104; Frances V. Cash, Executive Secretary, 295 Glessner Ave., Mansfield 44903, 419/526-8799. Third Thursday.

WAYNE: John K. Miller, M.D., President, 1706 Beall Ave., Wooster 44691-2378; Daniel E. Stump, M.D., Secretary-Treasurer, 1761 Beall Ave., Wooster 44691-2342. Meetings when called.

TWELFTH DISTRICT

Councilor: *Jack L. Summers, M.D.*, 75 Arch St., Akron 44304.

PORTAGE: Philip Kennedy, M.D., President, 9088 Superior Ave., P.O. Box 2489, Streetsboro 44240-5614; Atila N. Can, M.D., Secretary-Treasurer, 202 E. Summit St., Kent 44240-3650. Second Tuesday.

SUMMIT: C. William Keck, M.D., President, 177 S. Broadway St., Akron 44308; Linda A. Parenti, M.D., Secretary, 75 Arch St., Suite 401, Akron 44304; Shirley Bee, Managing Director, 430 Grant St., Akron 44311, 216/434-1921. First Tuesday, January, March, May, September and November.



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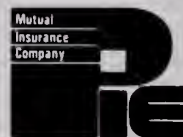
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continued on page 329

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OHIO: Emergency Medicine positions ranging from part-time placements to full-time directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insur-

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Massillon State Hospital, Box 540, Massillon, OH 44648, or call (216) 833-3135, ext. 228 or 229.

RADIOLOGIST — Our 13-physician radiology group has an immediate position for a Board-Certified radiologist with subspecialty training and interest in ultrasound at Akron General Medical Center. This position will be in charge of the ultrasound area, in addition to performing other general diagnostic work. Please submit C.V. to: Richard Skoblar, MD, Chairman, Radiology Department, Akron General Medical Center, 400 Wabash Ave., Akron, OH 44307, or call (216) 384-6450.

SOUTHERN OHIO — Seeking emergency department director for busy 200-bed hospital located in beautiful Ohio River Valley community. Board certification or board eligibility in emergency medicine or primary specialty with ED experience. Excellent salary with malpractice insurance provided and benefit package available. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

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continued on page 331

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Robert E. Stallter, Suite H, P.O. Box 331, 1011 Sandusky Street, Perrysburg, OH 43551, (419) 874-8080

Robert Dowdy, Edward J. Kupcho, Suite 111, 1 Commerce Park Square, 23200 Chagrin Blvd., Beachwood, OH 44122, (216) 464-9950

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continued on page 332

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state-of-the-art hospitals with total of 600 beds. Excellent acute care services. DO/MD welcome. Attractive city. Progressive leaders in a conservative community. Ideal for raising family. Superior recreational/resort areas for both summer and winter sports. Address inquiries to 1270 Rosedale Drive, Mansfield, OH 44906 (419) 756-5077.

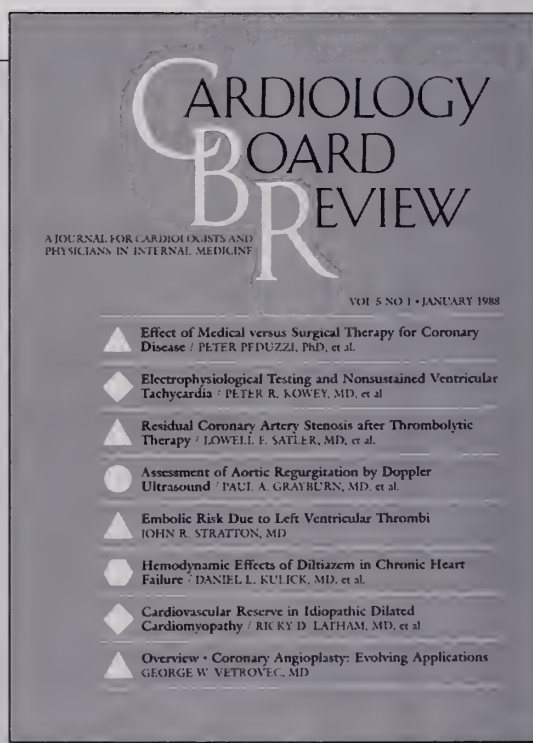
Correction

The fee for the "Urology Laser Symposium," which ran in the Continuing Medical Education section of our February issue, was printed incorrectly. The fee should have read \$425, instead of \$245 as published. *OHIO Medicine* regrets the error.

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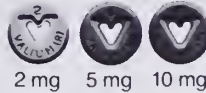
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VOL. 84, No. 5

MAY, 1988

ODH
AIDS Guidelines
Special insert

AIDS

The State of the State

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- Hospices
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In the depressed and anxious patient

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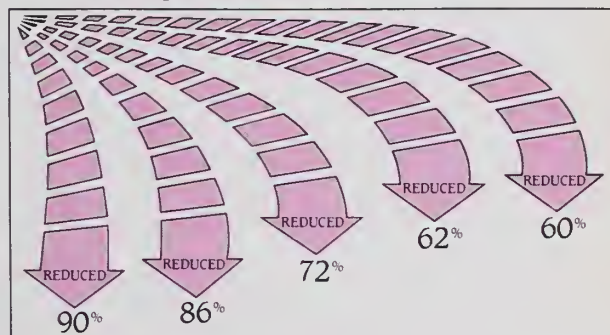
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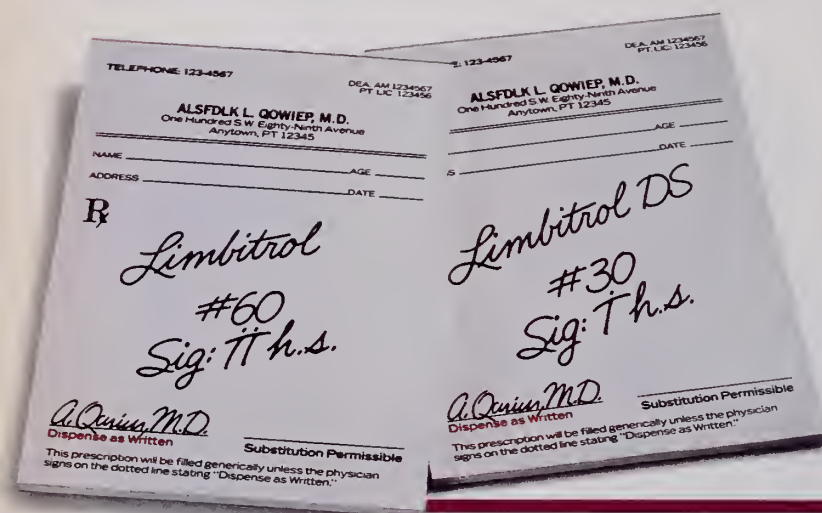
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Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

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FROM THE EDITOR

Subject Matter Reruns

(or why we persist in covering AIDS)

AIDS is one subject that is never long out of our pages. Last December, we updated you on the latest information with regard to AIDS testing, education and statistics.

This month, we turn our attention to different topics entirely. The Ohio Department of Health has revised its clinical guidelines for treating AIDS patients, and we've included them here as an insert. You may want to pull this information from the issue and keep it in your office as a handy resource.

"Where Will All the Patients Go?" takes a look at a growing problem in the state — where to house and care for AIDS patients who may have no family or other support system to turn to. The article explores one solution to the problem — the AIDS hospice — and reports on those facilities that are currently available in Ohio.

Associate Editor Deborah Athy has written an informative article that explores how the insurance industry is handling the costs of AIDS . . . and Editorial Assistant Michelle Carlson takes a look at what the state is doing, legislatively, on this issue. Even though these articles illustrate three aspects of the AIDS virus which have received little attention from us to date, we still don't feel as though we have covered this subject entirely. There is much that needs to be learned about AIDS . . . much that needs to be tried, researched and discovered . . . and

as long as that is the case, you can be assured that AIDS will remain a steady part of our contents for some time to come. Our responsibility after all, is to keep you informed, so we'll continue to keep you as up-to-date on this rapidly-changing topic as possible.

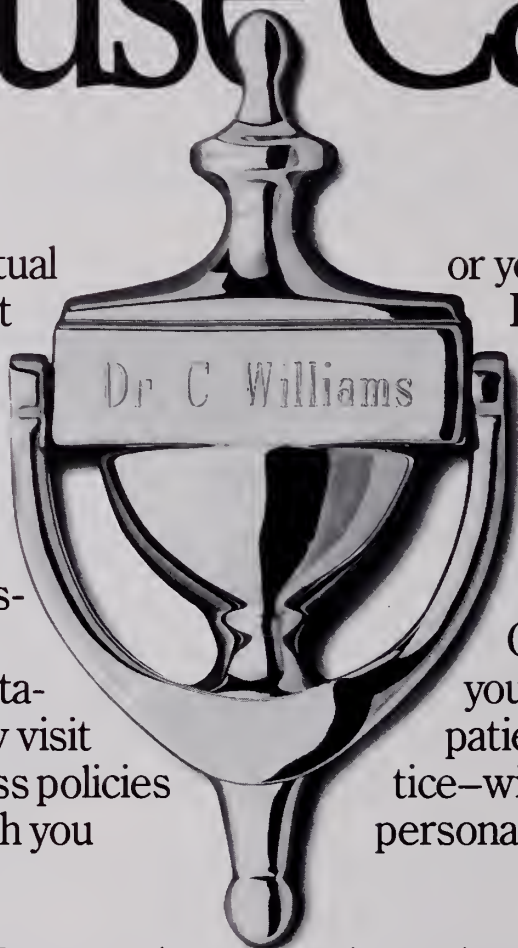
Also in this issue — our "Ohio Medi-scene" section features such a wide variety of topics this month, you're sure to find something of interest. Learn the latest on the care of Alzheimer's patients . . . how different county medical societies are battling the AIDS virus . . . what three county medical societies have had in common over the past year . . . and why medicine is going to the dogs. And you won't want to miss the "Out of Practice" article that describes Cleveland-area physician John Lombardo's experience in Calgary as chief physician for the U.S. Olympic team.

Next month, we return to yet another subject that has made frequent appearances on our pages — aging. Lately, there has been much technological advancement in this field, and that's the angle we'll be exploring. Watch for it — we think you'll find it both interesting and enlightening.

Karen S. Edwards

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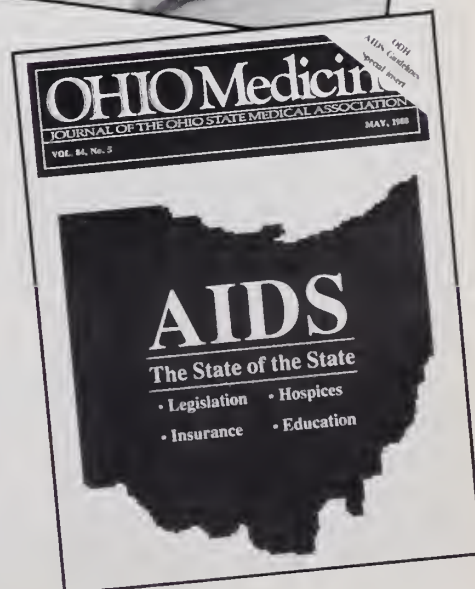
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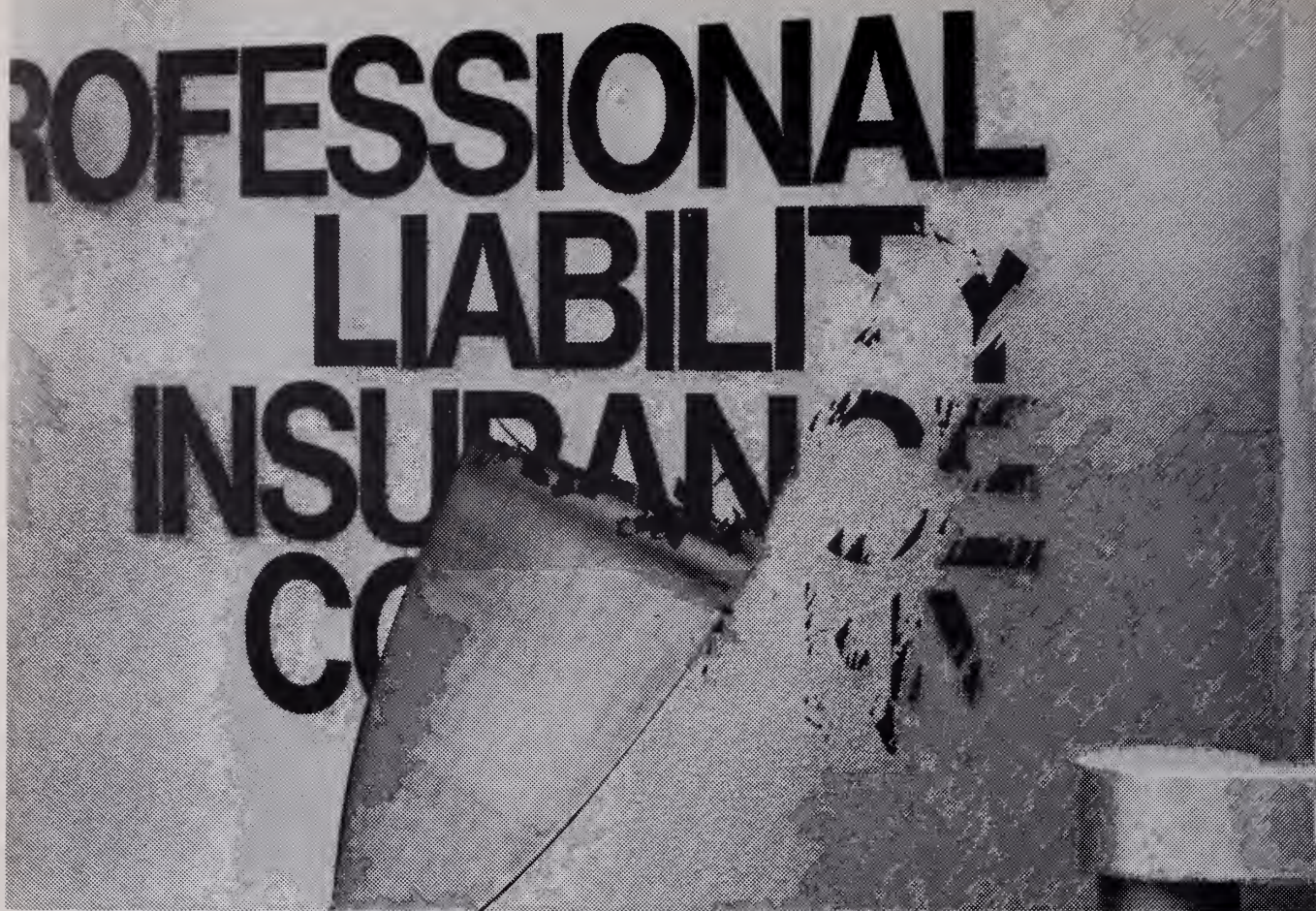
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MAY DAY, MAY DAY!!

By D. Ross Irons, MD

From time to time during the past year this well-recognized distress call has been heard emanating from the hallowed halls of medicine. It's no secret that medicine is under attack from many different quarters, as I have alluded to you in this monthly President's letter, and as a reader of *OHIO Medicine*, the specific entities and forces should now be well identified so there seems to be little reason to review that subject in its entirety.

But I think it is important to review our response to these problems. As organized medicine has scrambled to position itself to repel the attackers, it appears to me that a distinct weakness or chink in our armor if you will, is becoming apparent. It has created a division in our ranks, as each specialty or subgroup of organized medicine becomes more intent on preserving their own crops than guarding the barn or saving the farm. In other words, our solidarity of purpose seems threatened. And, looking down the road, this problem has the potential of worsening. Some of the questions we should ask ourselves are: "Will the relative value issue further splinter the common cause?" "Will large and well-funded PPOs further

subdivide the local physician population?" The list goes on. The truth is, inclement forces of division are at work. If ever the old adage "divide and conquer" is true, it is most assuredly true today as far as the health-care profession is concerned.

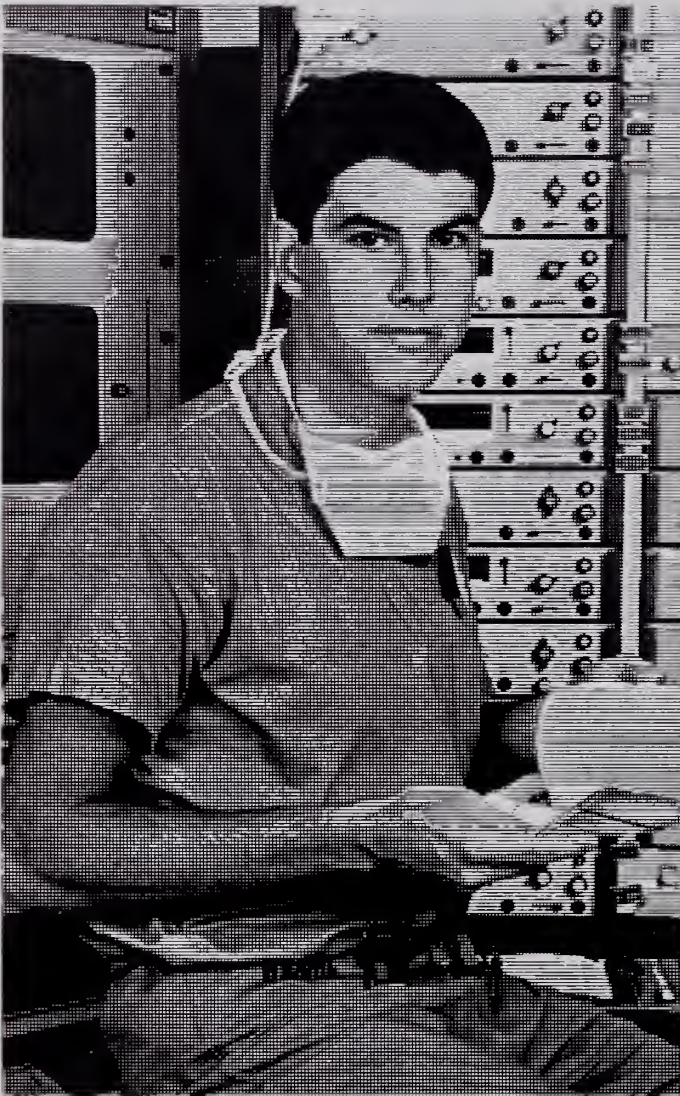
Therefore my call is not one of distress but more in the vein of "Rally around the flag Docs." Now I'm not suggesting that we dance wildly around the maypole but perhaps a movement toward solidarity would be most appropriate — if not absolutely essential — to the preservation of the union.

In closing this, my last President's letter, allow me to express my sincere appreciation for this opportunity to openly communicate with the OSMA membership. Also allow me to express my appreciation to the OSMA staff, and to all those members who took this opportunity to communicate with me and those at 600 South High Street.

There is no doubt in my mind that your Association has performed in an exemplary fashion during this past year. *THEY HAVE PROVIDED YOU WITH THE DIRECTION AND THE TOOLS TO ALLOW YOU TO BE*

IN CHARGE FOR A CHANGE. Each individual OSMA member now has the opportunity to define his own *challenge* and to find his own bootstraps as we move into this next year under the most capable and inspiring leadership of Dr. Donavin Baumgartner, Jr. **OSMA**

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LETTERS TO THE EDITOR

Trauma centers

To the Editor:

The article on Preventable Trauma Deaths in your January issue was interesting, but it may have raised more questions than it answered. How many of the "preventable deaths" occurred in the Level I trauma institution? Were those 16 deaths evenly distributed in the community or general hospitals, or were they concentrated in a relatively small number of the hospitals in the Columbus area? Is it possible that the surgery staff at a well-equipped general hospital might have a "preventable death" rate comparable to the rate at a "designated trauma center"? Would the authors of the article claim that errors in diagnosis and treatment never occur at trauma centers? In regionalized trauma systems, how often do paramedics overestimate the severity of trauma victims, resulting in unnecessary transport to an expensive trauma facility? Do hospital-operated helicopters reduce mortality rates or do they attract television cameras and favorable publicity? I hope that the OSMA Journal can provide answers to these questions before you ask the physicians of Ohio to climb on the trauma center bandwagon.

Cordially,
B.P. Luzzi, MD
Greene County, Ohio

To the Editor:

That injured patients are less likely to die when they are treated in a designated trauma center is no longer a matter for argument. The facts reported by Kudsk¹ clearly support the resource hospital-trauma team approach to patients with life- or limb-threatening injuries.

Kudsk's¹ series is small, but his findings are consistent with all other such reports.^{2,3,4} Whether

patients with head injuries should have been included in his analysis is debatable, and other questions about study methods can be raised. Nonetheless, two findings in this report bear further discussion.

The first is the striking rate of pre-hospital mortality (dead at the scene), which is considerably higher than expected from data from other regions.⁵ This should direct our immediate attention to a review of prehospital systems and possible system-wide reorganization.

The second is the reduction in unnecessary trauma deaths when patients were treated in an established trauma center. If these statistics are correct and reproducible, the implications for patient welfare and safety are large and should mandate the early establishment of an effective trauma system.

This question is far too important to ignore. The study must be repeated, perhaps under the sponsorship of the OSMA, enlisting area-wide cooperation from the EMS system, hospitals, medical examiners and coroners. The data collection should be comprehensive and uniform, and the results should be subjected to rigorous statistical analysis and should be published, no matter what the outcome. Unless we disprove Kudsk's data, we have no real basis to criticize his findings. Trauma is a major killer, especially for our youth. Our patients deserve to know the answer.

Olga Jonasson, MD

Robert M. Zollinger, MD

Professor and Chairman,
The Department of Surgery,
The Ohio State University
College of Medicine

References

1. Kudsk, KA, Fardal, PM:
Preventable trauma deaths. *OHIO Med* 1988; 84:56-61.

2. Shackford, SR, Hollingsworth-Fridlund, P, Cooper, GF, et al.: The effect of regionalization upon the quality of trauma care as assessed by concurrent audit before and after institution of a trauma system. A preliminary report. *J Trauma* 1986;26:812-820.
3. Cales, RH, Trunkey, DD:
Preventable trauma deaths: A review of trauma care systems development. *JAMA* 1985;254:1059-1063.
4. West, JG, Trunkey, DD, Lim, RC:
Systems of trauma care: A study of two counties. *Arch Surg* 1979;114:455-460.
5. Shackford, SR, Mackersie, RC, Hoyt, DB, Baxt, WG, et al.: Impact of a trauma system on outcome of severely injured patients. *Arch Surg* 1987;122:523-527.

AIDS response

To the Editor:

The number of acquired immunodeficiency disease syndrome (AIDS) cases in the United States has exceeded 50,000 cases as of February 1988. Over one million Americans are believed to be potentially infectious carriers of the human immunodeficiency virus (HIV). Virtually all projections for the future anticipate an increase in the number of cases and carriers.

Although rare cases of HIV transmission to health-care workers via medical devices (e.g. needlestick transmission) have been reported, there have been no reported cases of *patient-to-patient* HIV transmission associated with medical devices used for diagnosis or patient care. This is true in spite of the thousands of reusable medical devices that come into contact with HIV-infected patients and their potentially infectious body fluids every day. Good medical practice is essential to maintain this record. HIV is sensitive to many germicidal chemicals and currently accepted

sterilizing or disinfecting procedures are effective in killing this agent. Based on guidelines and strategies for control of the hepatitis B virus (HBV), the Centers for Disease Control has recently published updated recommendations for the prevention of HIV transmission in health-care settings, which include provisions appropriate for medical devices.

All members of the health-care community should cooperate in this infection control effort. Manufacturers should be knowledgeable of the sterilization or disinfection procedures that are both necessary for and compatible with their particular devices and materials and should communicate this information to users. Health-care professionals should be aware of recommended processes in handling, disinfecting and sterilizing medical devices that are used on multiple patients. Ancillary-care personnel must be properly trained and instructed in infection control procedures and must meticulously execute them. Many professional organizations are promulgating device or procedure specific recommendations in this regard, and we believe this trend should be encouraged.

Again, no cases of patient-to-patient HIV transmission via any type of medical devices have been reported. Infection control measures properly applied to medical devices that come in contact with body fluids can help prevent the transmission of HIV (as well as many other infectious agents) from patient to patient.

Ronald G. Kaczmarek, MD, PHS
Fellow, Office of Science and Technology

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Jerome Donlon, MD, PhD, Director, Division of Clinical Laboratory Devices, Office of

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Cancer and Interleukin-2

To the Editor:

Deborah Athy's thought-provoking article entitled "Cancer in Ohio: Keeping Track" (*OHIO Medicine*, February 1988) was very informative, but several aspects of that report cannot pass unchallenged. This is discussed in my editorial, "Cancer and Interleukin-2," a prediction which appeared in the *Southern Medical Journal*, March 1988. It presents solid data on how to implement a cure of that dread disease. Its conclusion bears repeating.

"It is difficult to avoid predicting that interleukin-2 produced in bacteria by high technology DNA synthesizing techniques will prove to be of only limited value in treating malignant tumors, while the antibiotics concept unquestionably will conquer cancer. With these thoughts in mind, considering that the triumph of the first successful landing of men on the moon cost great sums of money in only a few years, I propose that, using the conquest of infectious disease by penicillin and other antibiotics as a guideline, private industry and governments join hands in an equally costly effort to effectively defeat and destroy human cancer by implementing the concept of antibiotics including viruses in the form of vaccines."

The message from this summary is factual and to the point. It should not be ignored.

Sincerely,
Leonard B. Greentree, MD
Columbus

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(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

11. **CASE HISTORIES.** The *Journal* does not accept case histories.

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The Physician's Role — Advocate or Gatekeeper?

By Conrad Lindes, MD

Editor's Note: This article first appeared as a letter in the September, 1986 issue of the *Ohio Family Physician News*.

As the son of a country FP, my earliest perceptions of the medical profession were imbued with a deep respect for, and personal commitment to, the ideal of the family doctor as *the* contact point for anyone who had any health-related problem. In a rural practice, this included house calls, emergencies around the clock, helping break up domestic arguments, even inspecting restaurants. Sometimes, it meant delayed collections or payment in sides of beef or bushels of corn, or just plain charity care. But it always meant an unswerving dedication to do all that was possible to secure the best care for the patient and his family.

Above all, this commitment of the family physician as patients' "advocate" has distinguished us from all other specialties. We are trained to do as much for our patients ourselves as possible and to lead the health-care team of all ancillary and consultant services to see to it that the patient gets all necessary and appropriate care while being steered away from tests

and treatment of dubious value. The FP has always had a fiduciary responsibility, too, recently recognized by AAFP, to consider the costs of alternative management plans when advising the patient. After all, even "well-insured" patients pay for their health care sooner or later in the form of higher premiums, higher prices or lower take-home pay. All of these responsibilities are what we have been called to exercise as our patients' advocates.

Recent articles in the *Ohio Family Physician News* have used another term, one that should be odious to all FPs in calling us "gatekeepers." This title pictures a physician as a guard of a treasure hoard, wielding his profession and skills as weapons to beat back patients if they approach and only begrudgingly to allow entry to the most importunate or severely ill. This is not the role of a family physician.

I welcomed the concept of pre-paid care, in the way it links patients to me as their advocates. I am sure that I can provide better

and more efficient care to those who accept my overall management of their care than is obtained by those who "shop" on their own to get care from a fragmented array of practitioners. In my two years as medical director of a major HMO in Ohio, I steadfastly refused to use the term "gatekeeper," insisting on the concept of patient advocacy by physicians who, by the comprehensiveness and efficiency of their care, not by penury and skimping, would secure high-quality care at a cost that could compete with equally comprehensive and high-quality care through the unguided system. I am proud to say that most physicians with whom I had the honor to work during that time share my commitment and vision.

Thank God I am a family physician. May He never allow me to become a "gatekeeper."

Conrad Lindes, MD, is a family practitioner (not a gatekeeper) in Cleveland.

The Daily Telegraph

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A healthy balance

THE LAST thing the hard-pressed National Health Service needs is a slanging match between practitioners and senior Ministers on whom blame for public disappointment should be placed. Sides are better advised to sit down and discuss what the public want. The public is strongly in favour of yesterday's dental checks; and insofar as the medicine ultimately cuts costs, that view should not be too summarily ignored. Twice the number found in any previous survey, about one in five, see the NHS as the Government's most pressing problem. With other worries like the economy, unemployment, and the Government's central dilemma, it is not surprising. But the survey shows the NHS can only be put in certain things, less on other things. There is no question of health service spending is acceptable. The Government has rearranged priorities and 1 billion allotted in the autumn. Ministers will have to decide on this.

THE HEALTH SERVICE IN CRISIS

Urgent review is likely for NHS funding

Private sources may have to provide cash

Government must tackle the issue of funding for the National Health Service during this Parliament, cabinet ministers believe

• Guy's Hospital in London suspend new admissions to a special short-stay ward

Health Minister and Mr Kinnock agree on the need for a health service review



WEDNESDAY DECEMBER 16 1987

Baby unit doors closed by shortage of nurses

By Michael Horsnell

London has a shortage of nurses which Guy's is finding impossible to fill. And in recent weeks only the employment of nurses from private agencies, who sometimes account for more than 30 per cent of the unit staff, has kept the unit open. But despite the shortage, the number of babies waiting for treatment, particularly for ear, nose and throat complaints and orthopaedic surgery, there are still some 40 empty at any time. Pressure on the service has so increased that the staff of 2,900, including 300 consultants, 300 nurses and 300 other staff, are considered to be at the limit of their capacity.

THE Health Authority expect to be £1 million in the red within two years and is closing the City's 240-bed Royal Infirmary for two weeks over Christmas when it is expected to be a quarter full. Surgical and gynaecological patients will be transferred to West Cheshire General.

North West

THE 19 districts in the North West Region expect to overspend by £1.5 million by March, although they have reduced waiting lists from 62,620 in March to 60,393 in September.

About 22 patients a year

It said that 29,000 people were waiting for specialist treatment, ranging from a few weeks to a year, compared to 40,000 four years ago.

North East

ABOUT 350 beds were closed temporarily because of financial stringency, the North Eastern Regional Health Authority said.

A shortfall of £5,500,000 in the regional budget is expected by March, but it is hoped to balance the books by using up stocks of materials and paying creditors after April 1.

More ward closures likely as waiting lists grow

By Wendy Holden

A PICTURE OF growing waiting lists, a shortage of hospital beds and closed wards was emerging from around the country yesterday, as the Government announced its cash boost for the National Health Service. The country's regional health authorities reported being

taking "enormous" amounts of cash away from patient care. She is sponsoring a Bill to be introduced into the House of Commons in the New Year.

But while others agreed various economies to balance the books, Leeds West members refused to implement cuts to close

250,000 queue up for treatment

EXPRESS

ay December 14 1987

22p

Bigger role for private clinics in shake-up

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

England's National Health Service: Is It Ailing?

Editor's note: The information for this article was gathered from news reports collected by OSMA member Janet K. Bixel, MD, while on a recent trip to England.

All is not well in England.

The National Health Service, Britain's government-funded health-care system, is in the midst of a crisis, raising the levels of public concern to the highest they have been since the service began 40 years ago. And everyone, it seems, has somewhere different to place the blame.

"It's not surprising that the National Health Service is in trouble again," writes Brian Walden in an issue of the *London Sunday Times*. "The only cause for wonder is that there are still innocents in our society who believe a day will dawn when the NHS will be 'properly funded' by a government."

He goes on to say that since the NHS is not part of the open market, it has no rational mechanism for establishing priorities.

"The demand for its services is literally limitless and, as expensive advances in medical technology are inevitable, it is bound to overrun its budget. This trend will continue to accelerate rises in costs."

Others, most notably Prime Minister Margaret Thatcher, feel that the fault lies not so much in the program as in those who

administrate it, and have openly accused physicians and hospital consultants of standing in the way of a better NHS by "clinging to restrictive practices and deeply entrenched attitudes." This attitude appears to be based on work undertaken by officials at the Department of Health and Social Security who suggested that 70 million pounds a year could be saved if doctors improved by 1 percent the efficiency of the way they managed clinical resources.

Smarting under this blow, but refusing to enter in a "slanging match" with the government, medical professionals instead circulated a petition which expressed alarm at serious reductions in NHS recourses — cuts which, they claim, could endanger lives. The petition, presented at 10 Downing Street late last year, demanded an immediate injection of between 200 and 300 million pounds in the system, and a further 2 billion pounds to "make good" the reductions that have taken place over the previous six years.

The government has responded by providing an emergency increase of more than 100 million pounds in its allocation of funds to regional health authorities, but many feel the sum is too little, too late.

In Maidstone, Kent, for example, cutbacks have restricted

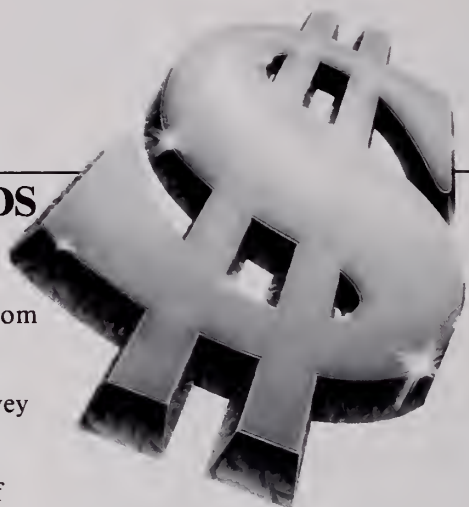
operations to emergencies only, and Guy's Hospital in London closed its door to further admissions of sick babies because of a chronic shortage of specialist nurses.

The Royal College of Nurses is predicting further shortages, however, as nurses have indicated they will leave the profession in a mass exodus unless pay scales and gradings can be improved. One survey claims that because of poor pay, one in five nurses has been forced to take a part-time job, and 60 percent regularly work unpaid overtime.

Morale among junior hospital doctors has also plummeted, causing many young physicians to leave the profession. One senior house officer who left his job to join a merchant bank says, "I left because of the appalling career prospects. I am 32 and I earn three times more than a hospital doctor. Now I get many letters from doctors wanting to come into the city. They ask questions like, 'Could I expect to earn more than 15,000 pounds a year?' I tell them that amount is pitiful by city standards."

"The real crisis of NHS," writes Walden in his *Sunday Times* article, "is that, perhaps understandably, successive

continued on next page



The high cost of AIDS

American life and health insurers paid out an estimated \$292 million in claims arising from acquired immunodeficiency syndrome (AIDS) in 1986, according to results from a survey from the American Council of Life Insurance (ACLI) and the Health Insurance Association of America (HIAA).

The survey conducted by the associations shows that the 275 companies responding paid out \$150.4 million in AIDS-related claims in 1986. These companies account for 46 percent of the life and health insurance industry's claims for four major product lines — individual life, group life, individual accident and health, and group accident and health.

The average AIDS-related claim for individual life insurance was \$30,500, and for group life policies, was \$27,300, the survey noted. In contrast, 84 percent of those responding companies which sold individual life had an average death claim of \$7,300 overall; for group life, the average claim was \$13,800.

According to ACLI President Richard S. Schweiker, "This survey indicates that American life insurance companies are paying out millions of dollars in AIDS claims. These numbers are only for a single year. The amount of claims is increasing each year, and the 1986 claims represent just the tip of the iceberg in measuring the impact that this disease will have on our industry."

Carl J. Schramm, president of the HIAA, said that the survey of 1986 claims "is the first in what will be an ongoing attempt to regularly measure the effect of AIDS on America's life and health insurance companies. We intend to collect this data regularly as an aid to forming both private and public policy."

NHS . . . continued

governments have lacked the courage to mend it or end it. They speak of it as if it were a piece of rare porcelain which must be admired from afar and never subjected to rough handling."

Two former health ministers, Sir Gerald Vaughan and Ray Whitney, have also stepped forward in support of change, indicating that the crisis was evidence that the time had come to abandon the "blind alley of paying for health care out of taxation." They called for a switch to a system of health insurance more responsive to market forces.

Others, more inventive in nature, have suggested the idea of a sweepstakes — a national lottery — to raise the money. All profits would go to the NHS.

Prime Minister Thatcher, however, continues to strongly refute claims that the hospital service is on the point of breakdown. Yet her Minister for Health, Antony Newton, has said that the government was pragmatically "moving down the track" of encouraging health authorities to link up with the private sector, and finding ways to boost their income from commercial sources. He further indicated that he would have no objection to health authorities subcontracting routine operations to private hospitals on a long-term basis — a statement that goes further, reports say, than previous pronouncements about partnerships between the two sectors.

Where the debate will lead has yet to be determined.

But, writes Walden, "The government must grasp the health nettle."

Bran-induced blockage

While the benefits of bran are frequently touted — especially by the manufacturers of hot and cold breakfast cereals — a recent report in *Archives of Surgery* may make fiber aficionados think twice before helping themselves to a heaping bowl of bran cereal.

In the report, James B. McClurken, MD, and Ned Z. Carp, MD, of Abington (Pa.) Memorial Hospital, say an otherwise healthy 50-year-old man sought emergency room treatment for abdominal pain. The man

apparently told the physicians he had eaten two large bowls of bran cereal several hours earlier. When X-rays showed a small bowel obstruction, the physicians operated and found the mass to be the bran, which had become a "toothpaste-like plug." It was promptly removed and the patient recovered.

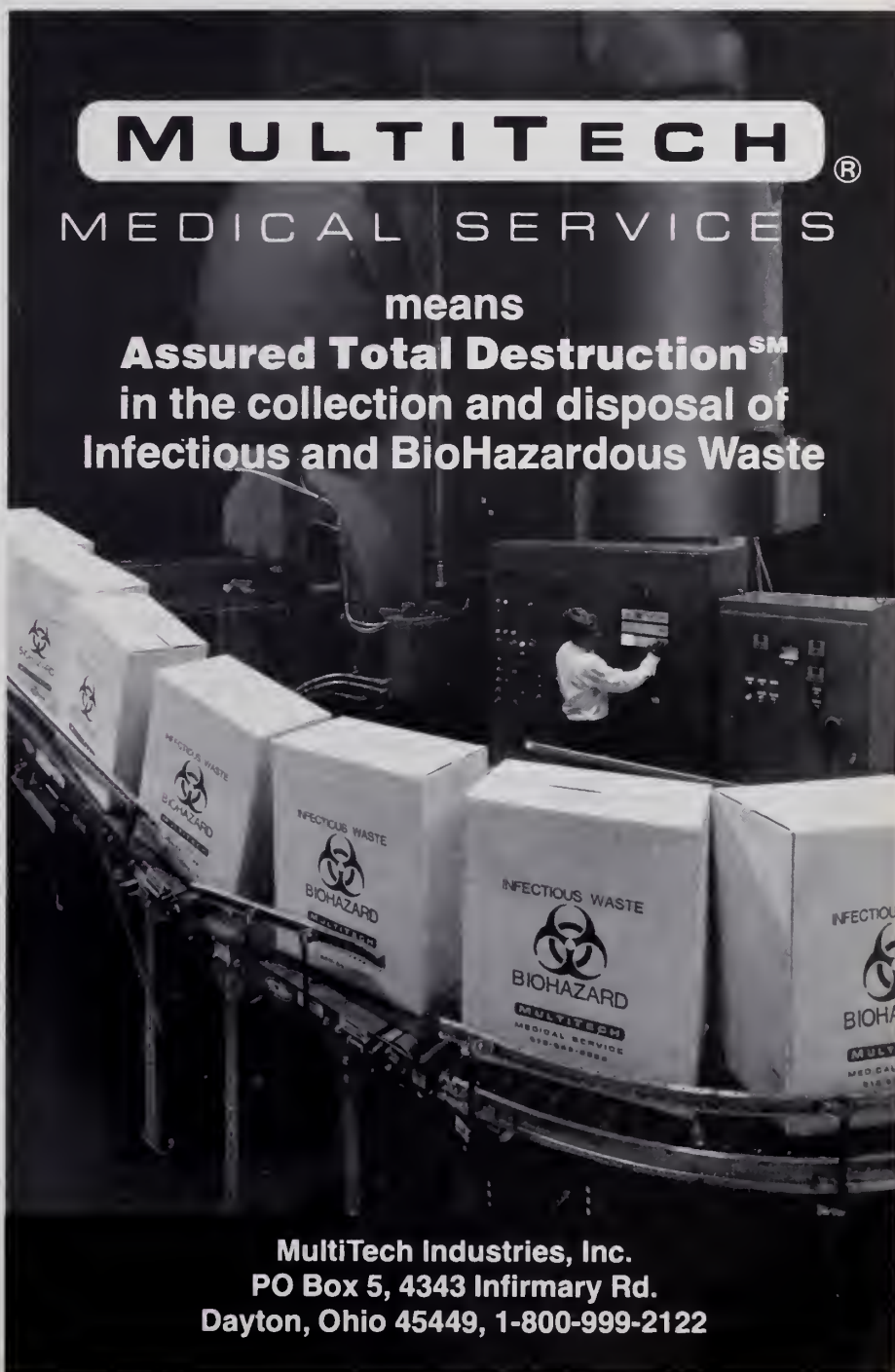
The report concludes that while infrequently reported, bran as a cause of such a blockage has "increasingly important implications in today's diet-conscious society."

COLLEAGUES

MALCOLM W. LENTZ, MD, a Gallopis general surgeon, has been named chief of staff at Veterans Memorial Hospital . . . **M.A. NAEEM, MD**, Elyria, has been named president of the medical staff at Elyria Memorial Hospital and Medical Center for 1988 . . . **MARVIN J. SCHEER, MD**, Rossford, has been named chief of pediatrics at St. Charles Hospital . . . **E.P. CANILANG, MD**, an Akron psychiatrist, has been named medical director of Edwin Shaw Hospital . . . **INAYAT MALIK, MD**, a Cincinnati urologist, has been appointed president of Bethesda Hospital's medical/dental staff . . . **RAVEENDRA B. RAVI, MD**, Conneaut, has been named chief of staff at Brown Memorial Hospital . . . **EMILY HESS, MD**, a Cincinnati psychiatrist, has been awarded the 1987 Mother Seton Award . . . **WILBURN H. WEDDINGTON, MD**, an associate clinical professor in Ohio State University's Department of Family Medicine, has been recognized with the Dedication Award during the university's recent observance of United Black World Week . . . **ORLANDO CASTRO, MD**, East Liverpool, has been elected president-elect of East Liverpool Hospital . . . **JAMES GARFIELD, MD**, Cincinnati, has been named president of the medical staff at Jewish Hospital . . . **ROBERT DAVIES, MD**, Springfield, has been selected to serve on the board of directors of the Great Lakes Regional Quality Assurance Association . . . **LEONARD SALTZ, MD**, Moreland Hills, has been elected for a third term as president of the medical staff at Deaconess Hospital . . . **PATRICK J. MULROW, MD**, Toledo, chairman and professor of medicine at the Medical College of Ohio, has received a Senior U.S. Scientist Award from the Alexander von-Humboldt Foundation in West Germany . . . **CHARLES P. PREZZIA, MD**, Middletown, has been named medical director of the occupational medicine program at St. Charles Hospital . . . **DAVID E. SCHULLER, MD**, Columbus, has been appointed director of the Arthur G. James Cancer Hospital and Research Institute at Ohio State University . . . **GEORGE ESHAM, MD**, Portsmouth, has been named chief of staff at Scioto Memorial Hospital for 1988 . . . **JACK P. STEINHILBER, MD**, Piqua, has been named chief of staff at Piqua Memorial Medical Center . . . **RICHARD FRATI-ANNE, MD**, Cleveland, a general surgeon at Cleveland Metropolitan General/Highland View Hospital, has received this year's Vocational Service Award

from the Cleveland Rotary Club . . . **PETER E. NIMS, MD**, Troy, has been named chief of staff at Dettmer Hospital . . . **BUEL S. SMITH, MD**, Akron, and **RICHARD H. CHAMPION, MD**, Akron, have both been elected to Akron General Medical Center's Society of Distinguished Physicians . . . **C. SCOTT HIRTH, MD**, Grove City, has been named medical director at Monterey

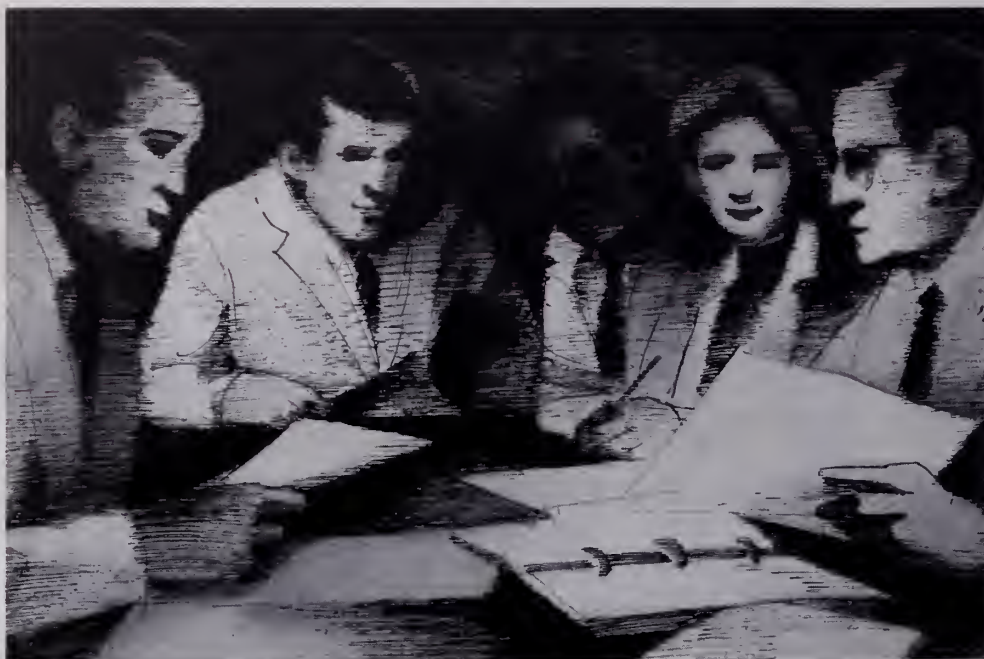
Nursing Inn . . . **HERBERT S. BELL, MD**, Cleveland, chief of neurosurgery at Meridia Huron and Meridia Euclid Hospitals, has been elected chairman of the Northwest Quadrant of the Joint Council of State Neurosurgical Societies . . . **RICHARD P. MORIN, MD**, Cincinnati, has been appointed director of the surgical intensive care unit at Jewish Hospital.



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Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93: 588-96.

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PRECAUTIONS:

Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

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Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

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The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978

2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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OHIO MEDI-SCENE

*Happy Canine Helpers . . . a home for Alzheimer's patients . . .
Medicaid tips . . . county societies wage war on AIDS . . . dermatologists
— more than skin-deep . . . OSMA physicians run for AMA . . .*

Why physical medicine has gone to the dogs...

When John Burkhart, MD, was a boy, he had a mixed-breed dog — “something between a Boston terrier and a bull terrier,” he says — who served as both friend and constant companion.

Now, as an adult, Dr. Burkhart is involved with dogs again — only this time around, the dogs are “constant companions” to someone else.

Four years ago, Dr. Burkhart became a board member of an organization called “Happy Canine Helpers,” which trains support dogs for the physically handicapped.

HCH is not a unique organization. There are other groups out there that train support dogs, and, of course, pilot dogs have been assisting visually-impaired people for years.

“Our training philosophy is different, however,” says Linda Allaby, the group's founder and executive director.

Because most handicapped persons do not have the strength, coordination or balance to give physical correction, HCH dogs are trained with praise and rewards, rather than with spike collars and electrical shocks.



Courtesy of Happy Canine Helpers

Happy Canine Helpers assist the physically disabled with everyday tasks such as turning on lights, opening doors and answering the telephones.

“That's part of what attracted me to Happy Canine Helpers,” explains Dr. Burkhart. “Dogs are God's creatures, too, and this group treats them humanely.”

Although the primary advantage, of course, is that the client need not use strength to control the dog, there is another, secondary benefit that is derived as well.

“Other people can approach the

dog, and that opens up communication between the handicapped person and those who normally have a tendency to avoid these people,” says Dr. Burkhart.

A specialist in physical medicine, with a practice in Columbus, Dr. Burkhart is familiar with the discrimination the physically handicapped person frequently faces.

OHIO MEDI-SCENE

Happy Canine Helpers . . . *continued*

"You hear about what an open society we have today, but it's not true," he says. "People will help a blind person, but they will walk right around a person in a wheelchair."

Unfortunately, that lack of acceptance has extended, in some cases, to the dogs themselves.

Despite a state law that allows support dogs the same accessibility rights as pilot dogs, there are still some schools, hospitals and other institutions that hesitate to let the animal in.

"It's only a problem because we're still new," says Dr. Burkhart. "People haven't heard of support dogs yet, so they're not as readily accepted as pilot dogs."

He tells of one incident where a school administrator refused to allow the dog in because it was felt it wasn't needed. "That's why we have teacher's helpers" was the excuse.

"What the administrator failed to realize is that it's awkward for a child, sitting in a wheelchair, to ask someone to come clear across the room to pick up a pencil," says Dr. Burkhart.

The happy canine helper can, and would, of course, pick up the pencil with ease — but retrieving fallen objects is only one of these pets' many capabilities.

"We train each dog, specifically, to meet the client's needs," says Allaby. Yet *all* dogs

are trained to retrieve objects — including dimes, and they will pick up paper without leaving teeth marks or holes. They also are taught to turn on light and emergency switches, to open both commercial and house doors and to carry saddlebags for school books or other objects.

Once the dog is placed in the client's home, then other, more specific tasks are assigned. Consequently, some canine helpers have learned how to help a patient in and out of the bathtub and/or bed; how to put a patient's legs on the bed; how to help someone in and out of a wheelchair; how to get help if it's needed; how to answer a phone; even how to remove socks.

An HCH staff member or trainer continues to work with both client and dog, even years after the dog has been placed. And, if the dog should become too old to serve the patient, another dog is brought in.

"Not to replace the other dog," says Allaby. "Our clients become very attached to these dogs, and would never part with them. So, we leave the older dog there and simply bring in another dog which can do the job."

Again, it's an example of the organization's humanistic approach to its business. As their brochure puts it, "our dogs wag their tails."

"I asked Linda about that one day," says Dr. Burkhart. "I pointed out the sentence, and said



'so what?' She told me it showed that the dogs are happy."

And happy dogs, according to Allaby, are approachable dogs.

"They won't growl if someone in the mall comes over to pet them," she says — and that's important to the staff, trainers and board members of HCH.

"We want people to approach our clients — even if, initially, it's only through the dog," she says. As a result, some breeds are turned away from becoming HCH pets because of their bad "public image."

"Normally, we take all breeds — mixed breeds, all kinds of dogs," says Allaby. Of course, they have to have the right physical characteristics — at least 24" high (27" for walking clients); at least 55 pounds in weight; strong-boned; and good temperament. But Allaby admits she will avoid Dobermans.

"I don't have anything against the breed," she says, "but a lot of people are afraid of them and won't approach them, so we generally don't use them — unless a client specifically requests one."

Even with all the right qualifications, however, the training period is a long one ("It takes about four or five months to train a dog before they can go into the home," says Allaby), and, of course, an expensive one. Although no charge is made to the client for the dog, the cost of training, feeding and housing a happy canine helper comes to approximately \$4,000 per dog.

Who pays?

Right now, service groups are funding much of the program, with the Lions and Kiwanis clubs providing the largest checks to date.

"We give a lot of talks to service groups," says Dr. Burkhart, who is working with a friend of his — the owner of Discovery Systems, Inc. — to produce a videotape as well as public service announcements for TV.

"We can always use dogs, and

we can always use more money," comments Dr. Burkhart.

And although he has not mentioned it, volunteer time is yet another need of the group.

Dr. Burkhart himself devotes about 10 hours a month to HCH — time he somehow manages to find and squeeze in between his practice; his work as co-chairman of the Columbus Academy of Medicine's Legislative Committee; his new role as Chairman of the OSMA's Committee on Workers Compensation and Rehabilitation Programs; and numerous church

obligations.

Anyone who wishes to become involved in the group on a volunteer basis (perhaps volunteering to do speaking engagements, for example) or who might wish to help the group in other ways should contact Linda Allaby, Happy Canine Helpers, Inc., 16277 Montgomery Rd., Johnstown, Ohio 43031, (614) 965-2204. They would also be happy to provide you with any further information. — *Karen S. Edwards*

A home for Alzheimer's patients

“Until there is a treatment or cure for Alzheimer's, care is really the issue," says Susan Gilster, a registered nurse and executive director of the Alois Alzheimer Center in Cincinnati.

Gilster talks enthusiastically about the center, which is thought to be the first of its kind in Ohio — and perhaps in the U.S. — to be devoted exclusively to Alzheimer's patients and their families.

"We take every opportunity to celebrate our success (the center's) and the success of our staff and patients," she says.

Some of the success may lie with the unique setup of the center itself. Occupying seven acres, the center has accommodations for 82 patients and features a barber/beauty shop, library, living room with fireplace, dining room/auditorium, activity room with whirlpool area, and private rooms for patient-family therapy.

Named for the German pathologist Alois Alzheimer, who described the disease in 1906, the center is affiliated with the University of Cincinnati and serves as a research and educational center for the study of Alzheimer's and related dementia.

Another boost to the center's success is the excellence of the staff, which includes nurses, nurse

assistants, a registered dietitian, and a wide range of medical consultants — from the patients' private physicians to ophthalmologists, dentists and other specialists.

"We have a special relationship with our staff," Gilster points out. "They are the link to our success."

Staff members participate in ongoing educational seminars, including stress and communications workshops, and contribute regularly to the programs at the center, she continues.

Education about Alzheimer's disease is given special attention on all levels at the center — for the patients, caregivers and families, as well as for the staff.

Caregiver seminars are offered to teach individuals how to take care of themselves while caring for an Alzheimer's patient. A few of the seminars include: Mental Health and Wellness: How to establish priorities when your own needs come first; Safeguarding Health; and Relaxation: Techniques for mental and physical relaxation. The center offers free day-care services for Alzheimer's patients while caregivers attend the classes.

Alzheimer's is a devastating

continued on page 353



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	Std.	Select	Std.	Select	Std.	Select	Std.	Select
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45	695.00	610.00	1345.00	1165.00	1990.00	1682.50	2615.00	2215.00
55	1457.50	1377.50	2870.00	2675.00	4277.50	3985.00	5665.00	5295.00
FEMALE NONSMOKER RATES								
Age	\$250,000		\$500,000		\$750,000		\$1,000,000	
	Std.	Select	Std.	Select	Std.	Select	Std.	Select
35	\$ 290.00	\$ 235.00	\$ 535.00	\$ 425.00	\$ 775.00	\$ 610.00	\$ 995.00	\$ 795.00
45	595.00	452.50	1145.00	845.00	1690.00	1232.50	2215.00	1625.00
55	1045.00	782.50	2045.00	1505.00	3040.00	2230.00	4015.00	2955.00

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Alzheimer's home . . . continued

disease that can become a "36-hour chore" for the caregiver, Gilster explains. "The caregivers become physically, mentally and emotionally worn out. They've become so intertwined with the patients that they give up their whole lives. They need to re-establish themselves with their own lives," she points out.

The respite care and day-care programs at the center are one way caregivers can get back on track in their own lives, she says. "The day-care program is set up to help the patients function at their highest potential for the longest period of time." Activities emphasize physical and mental stimulation that will benefit the patients in their everyday functions — at home and at the center.

The question of whether an Alzheimer's patient should move permanently into the center is one best answered by the family after considering a number of factors, Gilster says. For example, are there behavioral problems such as wandering and what is the support system like at home?

Safety features such as doors with alarms, enclosed patios and protective gateways make the center well-equipped to handle some of the special needs of the Alzheimer's patient on a full-time basis, Gilster explains.

Because change in environment is difficult for many Alzheimer's patients, the Alzheimer Center

strives to make the adjustment period as smooth as possible. The center works with the family and patient before, during and after admission to establish a plan of care and to discuss ideas and problems. "It really is a concerted effort," Gilster stresses.

Patients are welcome to bring personal items to the center with them — familiar items that can be used in a therapeutic way to jog the memory of the patient and cue them back into things that are meaningful.

"We plan the patient's care around what the patient is still attached to, the things they like," she explains.

The barber/beauty shop is one example of using the "familiar" to enhance the patients' behavior and memory. "The patients know that environment and they can cue in to all the things that are there. Often their behavior is very appropriate for that environment," she adds.

The long-range philosophy of the center is that "cure must be the only acceptable future for a disease that denies its victims a remembrance of the past."

But the Alois Alzheimer Center is passing its present test of success. Says Gilster: "We are able to meet the special needs of Alzheimer's patients and improve the quality of their lives." — *Deborah Athy*

Medicaid Tips

The Ohio Department of Human Services makes changes in the drug formulary quarterly.

Most additions and deletions are based upon recommendations presented by the Pharmacy and Therapeutics (P & T) Committee. The committee is comprised of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Waltenbaugh, RN; and Robert Reid, RPh, Chairman.

For your information, the following changes will appear in the April 18, 1988 Update.

ADDITIONS:

Anaprox DS 550mg; Aplisol; Beconase AQ; Ceftin 125mg, 250mg, 500mg; Cipro 250mg, 500mg, 750mg; Cycrin 10mg; Dimenhydrinate 50mg, INJ 50mg/ml; Diprolene Cream, Ointment; Diprolene AF; Genora 0.5/35; Indomethacin SR 75mg; Iodinated Glycerol 30mg; Keftab 250mg, 500mg; Lac-Hydrin; Megestrol 40mg; Minoxidil 2.5mg; MSIR Oral Solutions 10mg/5ml, 20mg/5ml, 20mg/ml; Nelova 0.5/35, 1/35; Prazepam 5mg, 10mg; Prozac 20mg; Rogenic INJ; Rowasa 4gm/60ml; Salflex 500mg, 750mg; Salsalate 500mg, 750mg; Trexan 50mg; Triamterene/HCTZ 75/50; Tridesilon Ointment; Trilisate 1000mg; Trimipramine 25mg, 50mg, 75mg; Tri-Tannates Tab, Ped Susp; Vancenase AQ; Vancocin 125mg, 250mg.

DELETIONS:

Compazine INJ 5mg/ml; Dalalone D.P.; Decadron INJS; Dia-Gesic; Keflet 250mg, 500mg; Limbitrol 5/12.5, 10/25; Navane 1mg, 2mg, 5mg, 10mg; Tranxene 3.75mg, 7.5mg, 15mg.

To keep you informed of changes in the Medicaid Drug Formulary your OSMA representative to the P & T Committee, Janet Bixel, MD, will keep you informed. — *Robert Reid, RPh, Janet Bixel, MD*

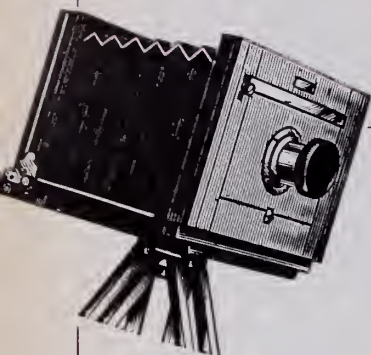
From the battlefield: How county societies are waging their own war on AIDS

If education is presently the only tool the medical profession can wield successfully against the AIDS virus, then county medical societies around the state are certainly doing their part to help win the war. Here is a look at a few of the programs that have been initiated at the local level. If

you have recently started a program, or have an ongoing one that is not included here, please let us hear from you. If you have no program yet, you may want to consider implementing one of the following in *your* county.

continued on next page

OHIO MEDI-SCENE



Lights, camera, action! An AIDS education film for doctors, by doctors

Cleveland

Since there is still much confusion in the medical profession surrounding the subject of AIDS, the Cleveland Academy of Medicine's Unmet Health Care Needs Committee has prepared a special videotape, designed to help physicians become more proficient at diagnosing, testing and treating the AIDS virus.

The film was financed through several different sources, explains Shirlee Leathers, the Academy's Public Relations Director.

"Our Academy Foundation had some funds in it, but not enough to cover the entire expense of such a project," she says.

With financial help from The Cleveland Foundation, the local hospital association and the medical school at Case Western Reserve University, however, the project was soon under way and donated services helped to keep production costs low.

"The producer of the program works on a health show at our local PBS station," says Leathers, "and she donated both her time and assistance."

Of course, so did the physician participants, so by the time the final bill for the videotape was tallied, costs came to about \$1,600 — most of it in camera time and director's fees.

"The tape itself is divided into five segments — epidemiology and transmission; the virus and

pathogenesis; clinical manifestations; testing; and AIDS in the practice," says Leathers.

Wilma Bergfeld, MD, the current President of the Cleveland Academy, provides an introductory message and Leonard Calabrese, DO, chairman of the AIDS project committee, presents one of the taped segments, in addition to serving as the program's moderator. Four physicians, experts in their area, are involved with the videotape's other segments.

An on-site speaker, or proctor, is present at each seminar to show the film, provide information between segments, distribute an up-to-date syllabus and field questions at the end of the tape's nearly 58-minute running time.

far away as Alaska. At least 800 physicians have seen it so far.

"We send it out all the time — to whomever requests it," says Leathers, adding that the tape, the folder of information that accompanies it, and even the project's theme have been copyrighted.

Other than keeping up with requests, the biggest job the videotape has created for Academy staff is keeping the all-important syllabus updated.

"The syllabus includes statistics, as well as local, state and national resources physicians can turn to for help," says Leathers. Proctors also need to be updated on the facts when — and if — a new angle presents itself. Only recently,

The Cleveland Academy's videotape is designed to help physicians become more proficient at diagnosing, testing and treating AIDS.

Finally, at the end of each seminar (which is worth two hours of Category I credit), a questionnaire is handed out to participants.

"Dr. Calabrese is gathering information (on physicians' knowledge of and attitudes toward AIDS) and is assembling it for a report he will write later," notes Leathers.

To date, the videotape has been well-received, and has drawn attention from medical groups as

for example, Academy staff members were busy updating both proctors and syllabuses on the new strain of the virus that surfaced late last year.

Still, Leathers insists, the film is not trying to make those physicians who view it instant experts on the subject.

"All it tries to do is give them as much information as possible; encourage them to be non-judgmental toward the patient; and allay some of the fears that they

or the health-care workers in their offices may feel," she says.

Dr. Calabrese would like to follow this initially successful film with a sequel — a videotape for those who have seen the first one and require more advanced instruction or information.

The Academy, meanwhile, is proceeding with a second-prong attack — an AIDS education campaign which is geared toward the public at large.

"We've produced some posters for physicians' offices," says Leathers — again using donated services, (this time, the creative talents of a local advertising agency). The Academy is waiting to see, however, if additional funding might be found for further public education efforts.

"Orlando on a pint": Belaying the fear of blood donation

Lorain

In Lorain County, ignorance seemed to be winning the war against AIDS . . . or at least, that's the way it appeared recently when the county's blood supply dropped to dangerously low levels.

"There are still people who are afraid they can get AIDS from donating blood," says Shirley Dalton, executive secretary of the Lorain County Medical Society.

So, to call attention to the problem, and to boost confidence in donating (as well as the number of pints in the blood bank), the medical society decided to sponsor a program which appealed — as Dalton puts it — "to the gambler in us all."

For every pint of blood given, the donor's name was placed in a drawing — the winner of which would receive a free trip for four to Orlando, Florida, the home of Walt Disney World, paid for by the Lorain County Medical Society.

"A number of our members volunteered their time to support the project, and to answer questions," says Dalton.

Booths featuring AIDS

information and displays were set up near the donation stations, and Auxiliary members were on hand to serve refreshments to donors and to provide child-care help where needed.

Lorain County President Romeo Miclat, MD, was also kept busy promoting the program on radio and TV.

"It was a phenomenal success!" says Dalton.



Over 260 pints of blood were drawn the first day, and by the time the event was finished, the Lorain County blood bank was 1,000 pints richer.

And, thanks to the Lorain County Medical Society, one couple (with two young children they elected *not* to take) will soon be flying to Orlando, Florida for their four-day, three-night vacation.

Doctors on Call Mahoning County

A new, nine-member AIDS Awareness Committee, recently formed by the Mahoning County Medical Society and composed of health-care professionals who are "in the

forefront of AIDS testing and medical service to AIDS patients" will soon be taking an active role in AIDS education and counseling.

Committee members, including Chairman Chatrchai Watanakunakorn, MD, will make themselves available to discuss AIDS-related topics such as prevention, treatment and transmission with schools, businesses and service groups. In addition, the physicians will respond to calls from an AIDS hotline. Each call will first be fielded by a Mahoning County Medical Society staff member, who will refer callers to the committee member best suited to answer their question. In-person counseling sessions will be arranged if requested, and all services will be provided free — and will be confidential.

Despite the fact that other community services are providing AIDS patients with educational and counseling services, the Mahoning County Medical Society believes that there may be some instances in which a medical professional might be more helpful — or more knowledgeable.

Committee members are also considering offering an AIDS testing program to provide those who may be uncomfortable with the testing provided at the Youngstown Health Department's Sexually Transmitted Disease Clinic an alternative site.

Compiling resources on AIDS Columbus

The problem with a grapevine is that it can provide as much misinformation as information — so when members of the Academy of Medicine of Columbus and Franklin County's Committee on AIDS learned that the "grapevine" was creating problems for hospitals that had drawn up AIDS policies, they decided to get to work.

"They learned that health-care workers were taking a look at policies created outside of their

continued on next page

OHIO MEDI-SCENE

Waging war on AIDS . . . *continued*

hospital, and wondering whose was better," says Ann Clinger, the Academy's Deputy Executive Director.

The committee, therefore, has assembled and published a "model AIDS policy" for hospitals, which is currently being offered to *all* of the Columbus area's health-care institutions.

"They are not required to use it," says Clinger, "but we hope they will."

The guidebook includes a generic "personnel policy," for example, on how to deal with an AIDS patient, while another

section discusses the proper management of blood and body fluids.

Anyone who would like further information on the guidebook should contact Ann Clinger at The Academy of Medicine of Columbus and Franklin County, 525 Metro Place, N., Suite 440, Dublin, OH 43017.

Since hospitals aren't the only entities requiring resource information on AIDS, however, the Academy's AIDS committee has recently spun off a subcommittee which has just published an AIDS brochure of its own. This one is a

community resource guide for patients with AIDS or ARC, and for members of the patient's family.

This guide includes information on where to go for counseling; financial assistance; help for alcohol and/or drug addiction; legal assistance; testing; child-care; even medical referrals. Information on funeral services and local AIDS hospices is also included, as are AIDS information hotlines. Again, anyone who wishes further information on this project may contact Clinger at the address above. — *Karen S. Edwards*

Dermatologists: More than skin-deep in medicine

There are barely 6,500 of them in the United States.¹ Of those, a scant 225 can be found in the state of Ohio.² And while they're hardly considered an endangered species, dermatologists *are* members of a relatively small specialty (in terms of numbers). But don't let the numbers fool you. Dermatologists — including several right here in Ohio — are making inroads in organized medicine that belie the group's size.

"Across the country, dermatologists are making their specialty known," asserts Wilma F. Bergfeld, MD, president of the Academy of Medicine of Cleveland. "Dermatologists are members of a minority group, but they're filling a great need in medicine."

Dr. Bergfeld, who is also president of the Ohio Dermatological Association, says dermatologists — as well as other specialists — are slowly but surely stepping to the forefront of organized medicine.

"Particularly in Ohio," she notes, "(dermatologists) are having a definite impact on organized medicine. It transmits a message to other specialties to get on the ball."

Coming from a family of physicians, she says — her father and grandfather were both general surgeons, and she is married to an orthopedic surgeon — has not only helped broaden her base, it has also allowed her to recognize the concerns of all physicians — not just dermatologists.

"One of my intentions is to



*Wilma F. Bergfeld, MD
President, Academy of Medicine
of Cleveland*

bring other capable physicians into the system," she says. "I personally feel that what I'm doing is representing physicians. I think I'm opening the door for others."



*K. William Kitzmiller, MD,
President, Cincinnati Academy
of Medicine*

Keeping in touch

K. William Kitzmiller, MD, a Cincinnati dermatologist, is equally enthusiastic about his participation in organized medicine. "I think it's kind of neat. It puts me in touch," says Dr. Kitzmiller, who is president of the Cincinnati Academy of Medicine. "I have an overview of organized medicine in my community."

"As far as uniqueness is concerned," he continues, "I think that it shows the interest (on behalf of) the specialty."

One possible advantage a dermatologist might have in serving organized medicine, says Dr. Kitzmiller, is the relatively rare occurrence of having to attend a patient in the hospital.

"I'm able to maintain a private practice and maintain certain hours, so I'm available for meetings," he points out, adding that he frequently schedules such business during the early morning hours or during lunch.

"On the other hand," he says, "the president of the OSMA (D. Ross Irons) is a surgeon, so I think to some degree it depends on

the nature of the individual physician who chooses an active role in organized medicine.

"I think if a president is a good administrator, he'll have competent advisers to aide and guide him — the specialty groups will tell them their problems."

Bridging the gap

A few years ago, Alvin H. Niemer, MD, a Middletown dermatologist, probably couldn't have imagined himself assuming an active role in organized medicine.

"I'd been a solo operator for quite awhile," explains Dr. Niemer, "when someone in the community asked if I'd take on a delegate slot (to the OSMA)."

"I went to a few delegate meetings and one thing led to another. It was sort of a progression," says the man who now heads the Butler County Medical Society as president.

"Many dermatologists have taken the opportunity to cluster in their offices," says Dr. Niemer, explaining the rather roundabout way in which he took office. "They just aren't very interested in mainstream medicine, the political end of it."

"It's probably indigenous to the specialty," he continues, "because you don't participate in hospital activities too much. You just don't



*Alvin H. Niemer, MD,
President, Butler County
Medical Society*

continued on next page



*Jerome Kimmelman, MD
Chairman, Board of OMPAC*

OHIO DERMATOLOGICAL ASSOCIATION

Statewide skin cancer detection day is, Saturday, May 21, 1988. Committee sites will be held at:

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Cincinnati
Cleveland
Columbus
Dayton
Medina
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Skin screening program previously held in:
**Cincinnati and
Dayton.**

Each effort will be coordinated through and implemented by the local societies and local communities. For further information regarding time and place contact the American Cancer Society.

OHIO MEDI-SCENE

Dermatologists . . . *continued*

have much contact with other people outside your office.”

While Dr. Niemer does not believe his participation will necessarily encourage other dermatologists to do the same, he still believes dermatologists have a distinct voice in medicine.

“Right now there’s a dichotomy, friction if you will, between the cognitive and procedural parts of medicine,” he explains.

“Nonsurgical types sometimes complain their awards are nowhere near the surgical incomes . . . the complaint has often been that there is a discrepancy in economic awards. Where dermatologists come in,” he continues, “is that we bridge both gaps — cognitive and procedural — in our daily practice.

“Given this argument, debate — whatever you want to call it — dermatologists are able to view it from both perspectives.”

But while the ability to see both sides of the story may indeed be

an asset, Dr. Niemer points out that sometimes, “It’s sort of an obtuse advantage.”

Facing the crisis

Jerome Kimmelman, MD, is a strong believer in organized medicine. So strong, in fact, that four years ago the Toledo dermatologist assumed the role of Chairman of the Board of OMPAC — the political action committee of Ohio physicians. (In addition, he is an alternate delegate to the AMA from Ohio.)

“I just feel very strongly about the problems facing medicine today,” explains Dr. Kimmelman. “We’re facing a crisis situation in medicine. It’s changing completely.”

Though Dr. Kimmelman acknowledges that he is a member of a rather small specialty, “I am a physician first,” he says, “and I’m fighting for the patient.”

Still, he hopes that his visible role in medicine will encourage others to join. “I do a lot of

talking across the state,” he notes, “trying to get physicians to get involved in the legislative end of medicine.”

Dr. Kimmelman is unsure whether being a dermatologist has enhanced his role in organized medicine, but he will offer this: “We have as much or more patient contact as any other specialty, so we know what’s affecting the patient. Most dermatologists see about 50 to 75 patients a day, so we know what their concerns are. I think that’s an important asset to have when you’re in medicine.” — *Michelle J. Carlson*

¹ According to Jan. 1988 membership figures from the American Academy of Dermatology.

² According to March 1988 membership figures from the Ohio Dermatological Association.

Four OSMA physicians run for AMA offices

Four Ohio physicians are seeking positions on various councils of the American Medical Association. All four are endorsed and sponsored in their candidacy by the Ohio State Medical Association and its delegates to the AMA.

John E. Albers, MD, Cincinnati, is a candidate for re-election to the AMA Council on Medical Education. A former OSMA President, Dr. Albers has served two terms on that Council, beginning in 1982, and has drawn upon his experiences as a

practicing physician, clinical professor and leader of organized medicine to help the Council consider and evaluate the educational needs of future physicians, as well as the needs of students of the allied health professions.

H. William Porterfield, MD, Columbus, is seeking a first-term position on the AMA Council on Medical Service. Dr. Porterfield left his plastic surgery practice in 1986 to assume the top management role of Physicians *continued on page 360*



John Albers, MD

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Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient, when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently: serious toxicity is not reliably preceded by less severe side effects.

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with epinephrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether the bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets: The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered

1. Every 24 hours in children under 12 years of age, have not been established.
2. Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

1. Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.
2. Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.
4. Respiratory: tachypnea.

5. Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuretics.

6. Other: rash, hyperglycemia and inappropriate ADH syndrome.

OVERDOSAGE: Management: If potential oral overdose is established and seizure has not occurred:

- A. Induce vomiting.
- B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken).
- C. Administer activated charcoal.
- If patient is having a seizure:
 - A. Establish an airway.
 - B. Administer oxygen.
 - C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
 - D. Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Care:

- A. Maintain airway and oxygenation.
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis; however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert. Revised 6/87

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OSMA physicians . . . continued

Health Plan of Ohio, a delivery system formed by the Academy of Columbus and Franklin County. This position has allowed him to observe both the private practice of medicine, and that of an alternative care system on a first-hand basis. His insight into both worlds would greatly enhance the Council if he is elected to serve.



H. William Porterfield, MD

Richard M. Steinhilber, MD, Cleveland, is seeking re-election to the AMA Council on Scientific Affairs. A background in family medicine, psychiatry/neurology and emergency medicine has made Dr. Steinhilber an invaluable asset to the Council since 1985, because of the variety of issues that come before it. His unique medical background, experience in practice and proven leadership abilities make him an eminently qualified candidate. Dr. Steinhilber is also endorsed and sponsored in his race by the American Psychiatric Association.

Frederick T. Suppes, MD, Cleveland, is a candidate for the position of member-at-large of the AMA Hospital Medical Staff Sections Governing Council. A

continued on page 420

In Search of the Great Compromise

The Insurance Industry and the Cost of AIDS

By Deborah Athy



It's been said that there are two sides to every argument. Sometimes these sides mix together about as well as oil and water.

AIDS is a subject that tends to draw out these dichotomies in our society. At issue here is the cost of AIDS and who's going to pay the bill — the insurance industry, the patients, the government?

An element of little surprise is that the real "deep pockets" — the source that's going to be tapped for the AIDS bills — has yet to stand up and be counted.

What the insurance industry says: "We're a business. We ought to be able to find out what the risk is before blindly underwriting policies. AIDS should be treated like any other disease."

What the other side says: "Insurance companies are attempting to screen out individuals based on factors other than past and present health. Demanding that all single men

over age 25 be tested for AIDS is discriminatory and an invasion of privacy."

And from here the discussions continue, resembling the dueling banjos of discourse . . .

There's no question that the insurance industry has much at stake. Perhaps this explains why the Ohio Department of Insurance created the Insurance AIDS Task Force in August 1987. Made up of appointees from a number of disciplines — insurance, medicine, law, community organizations — the task force was composed of three subcommittees: underwriting, legal and benefits limitations.

"I wasn't surprised that the insurance agency was trying to protect its profits, trying to protect its turf," says Joan Wurmbrand, MD, a Gahanna family practitioner and member of the legal subcommittee. "I also want to protect my turf. But my turf is the health and welfare of the people of Ohio."

A. Robert Davies, MD, medical director of Nationwide Insurance, served on the underwriting subcommittee. "The subcommittees turned out to be arenas, forums for debate on such things as AIDS testing, the validity of testing, the rightness and wrongness of testing, what kinds of questions should be asked and which constitute unlawful discrimination," he explains.

These issues are also addressed in Senate Bill 353, the broad-based AIDS bill sponsored by State Senator David Hobson (R-Springfield). SB 353 was introduced in January 1988 and



"As I stand back and look, the process of figuring out is not 'Is there a problem and how big is it?' or 'Who's going to pay for it?' but 'Who's going to pay for it before the money runs out?' "

**— A. Robert Davies, MD
Columbus**

has been referred to the Ohio Senate Health, Human Services and Aging Committee.

Section 3901.45 of the bill states that insurers cannot take an applicant's sexual preference into account nor make inquiries about marital status, living arrangements, occupation, gender, medical history, or ZIP code to ascertain the applicant's sexual preference.

This section applies only to individual policies. So far, there are no testing requirements for group policies.

"Most everyone agreed that it wasn't fair by virtue of where a person lives or by their occupations (except high-risk occupations such as car racing) to select applications for approval or disapproval in underwriting policies," Dr. Davies points out.

But according to a recent news account, one insurance company issued guidelines for its underwriters to deny coverage to single men without dependents

who worked in "suspect" occupations — those not requiring physical exertion, including antique dealers, fashion designers/consultants, florists, interior decorators and restaurant workers. The guidelines were later withdrawn under the threat of litigation.

"Most committee members felt it was not fair to underwrite based on sexual preference and lifestyle," continues Dr. Davies, an OSMA delegate and Ohio delegate to the AMA. He points out that, apart from AIDS, there are no documented statistics to show that a homosexual lifestyle is necessarily high risk. On the other hand, heart attack risk has been well-documented and statistics are very specific per 1,000 individuals, he notes.

From this point on, however, opinions began to vary widely, he admits. The dueling discussions were struck up, and the most extreme points of view were, in fact, as distinct as oil and water.

Dr. Wurmbbrand, president of the medical staff at St. Ann's Hospital and also a member of the OSMA AIDS Task Force, says, "I don't think some of the non-medical people, and some individuals in the medical field, have a full grasp of the magnitude of the problems associated with AIDS. They don't consider the ramifications of their decisions."

Because of the immensity of the subject, the dialogue often became convoluted and dragged down with facts and figures. "The discussions got obfuscated by a lot of statistical analysis," Dr. Davies admits.

The topics discussed covered both ends of the spectrum. An extreme view that didn't garner much popularity was to limit benefits for AIDS-related illnesses. "This concept was pretty much ruled out by the committee," Dr. Davies recalls. "The insurance agency shouldn't be able to exclude AIDS."

On the other side of the coin is the concept that health insurance is an unalienable right rather than a privilege, he continues. This philosophy, he says, "doesn't ring true like crystal when you ping it with your finger."

If only there *were* such a test one could use to balance the scales of justice . . . Instead, the debates continued.

"Health insurers want to be able to test if there's anything on the questionnaire that suggests illness," according to Dr. Davies. "The companies should not be snooping for AIDS, but should be looking for all illnesses."

"I tried to represent the view of the practicing physician and an OSMA-appointed physician," he continues. "I feel it ought to be fair to find out what the risk is. AIDS ought to be treated like any other disease. But if you take this point of view, you're cast as a fat cat insurance company."

Says Dr. Wurmbbrand: "We've always said, 'Yes, you can screen for diabetes and other diseases,' but certain social issues have precluded the insurance agency on certain diseases — sickle cell anemia, for example." According to Dr. Wurmbbrand, AIDS may fall into this category.

SB 353 also addresses some of these issues:

- "The insurer may ask the applicant specifically whether he has ever had a positive result on an HIV-related test."
- "The insurer may ask the applicant if he has ever been diagnosed as having AIDS or an AIDS-related condition."
- "The insurer shall not ask the applicant whether he has ever taken an HIV-related test."
- "... an insurer may require the applicant to submit to an HIV test only in conjunction with tests for other health conditions."
- "An insurer that requests that an applicant take an HIV-related test shall obtain the applicant's written consent for the test and

shall inform the applicant of the purpose of the test." This includes "information about the tests to be performed, the confidentiality of the results, procedures for notifying the applicant of the results and a general interpretation of test results."

- "The insurer shall notify the applicant of the results of the test and give the applicant printed material interpreting the results of the test and a list of counseling services . . ."

- "An applicant may be required "to submit to HIV tests when no other health conditions are being tested for if the insurer can demonstrate (to the Superintendent of Insurance) that its financial stability is threatened by the number of AIDS claims it has received." However, this does not apply to HMOs.

At present there are no carved-in-stone standards being applied in the insurance community. Some companies are testing, period. Others have pulled out of some parts of California and the District of Columbia because of anti-testing legislation.

"The standards have to be fairly applied by the insurance company," Dr. Davies points out. But he adds, "It's not fair to get insurance if you're already sick."

Dr. Wurmbbrand points to the issue of pre- and post-test counseling as another important area of concern. "We have a remarkable system of counseling centers for testing, but insurance companies in Ohio are reluctant to acknowledge that this is an important aspect — which is irresponsible," she says.

The Centers for Disease Control (CDC) and other health agencies have stressed that pre- and post-test counseling are an integral part of the testing procedures, she continues. "The insurance companies have said, 'We're not in the business of counseling' and have not come up with a satisfactory method of

counseling."

Another area of debate focuses on the accuracy of the HIV tests themselves. Dr. Davies says, "There's a lot of talk about the accuracy of the AIDS testing based on a lack of understanding." The standard in the insurance community is to use two positive ELISA tests and one Western Blot to determine HIV status — the accuracy of which is phenomenal, he states.

The frequency of false positives has also caused some clamoring. But according to Dr. Davies, the number of false positives per 1,000 or 10,000 is very low, depending on the population you're testing.

He says, "Opponents have made this a very big problem, but it's not very likely."

In fact, he even questions whether there is such a thing as a false positive, citing a current study that suggests individuals who tested false positive eventually begin to show signs of being positive.

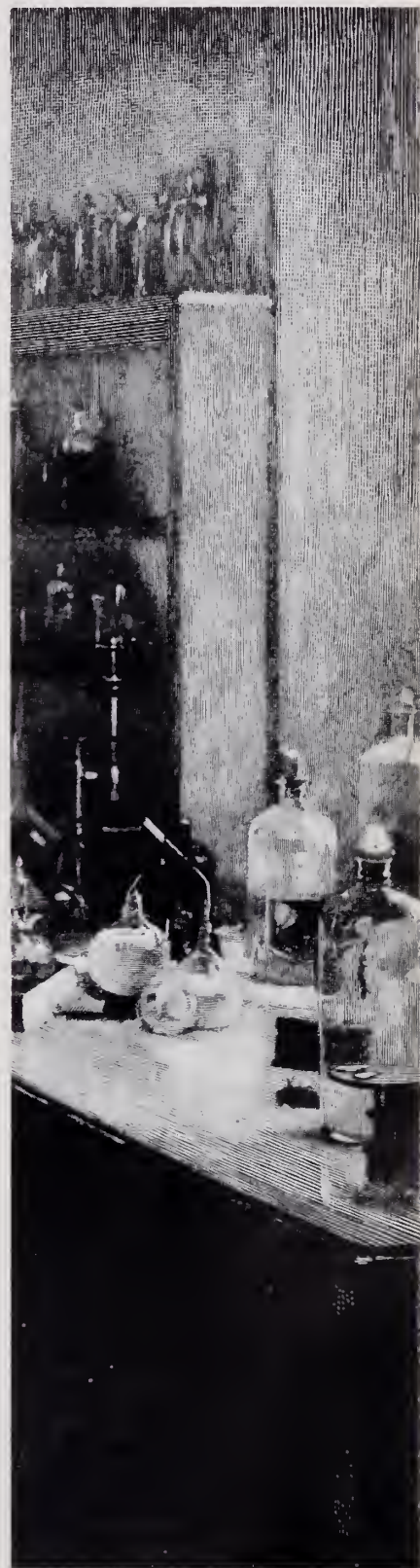
But Dr. Wurmbbrand believes the concerns about the frequency of false positives are valid. "There does seem to be an unfortunate number of false positives in the low-risk categories," she says.

Another area of debate addressed by SB 353 is that insurers cannot cancel or refuse to renew insurance policies based solely on the fact that the policyholder has been diagnosed as having AIDS.

Dr. Davies agrees. "If individuals have valid policies that they've gotten before they were sick, they're covered.

However, the carpet may be pulled out from underneath these individuals if they lose their jobs and their insurance is cancelled. But this becomes an employee issue, not an insurance issue, Dr. Davies stresses. The patient should be covered under the employer's disability plan.

"As I stand back and look, the process of figuring out is not 'Is





"Unfortunately, there's no pot of money to pay for the AIDS problem."

there a problem and how big is it?' or 'Who's going to pay for it?' but 'Who's going to pay for it before the money runs out?' " says Dr. Davies.

Carolyn Towner, Associate Director of the OSMA Department of Legislation, addressed this problem when she gave testimony before the Ohio House on SB 353. "We cannot pretend AIDS is someone else's problem," she said. "AIDS is everyone's problem, and SB 353 attempts to address many of the issues surrounding AIDS."

After reviewing the bill, the OSMA AIDS Task Force recommended that the OSMA support the bill with specific recommendations.

With SB 353 moving in to tackle the AIDS questions in a broader sense, the findings of the AIDS Insurance Task Force may recede a little into the background.

As Dr. Wurmbrand points out, "We have to step back and look at everything. We can't look just at special interest groups such as insurance companies. There are about 30,000 to 40,000 HIV positives in Ohio at present. If we do a little multiplication, we can compute the magnitude of the problem."

According to the CDC, an AIDS patient may accrue some \$150,000 in medical bills before death. A recent report projected the total AIDS price tag to reach \$8.5 billion by 1991.

So the question of who will pay or even who will pay first is not a

question that is likely to go away any time soon. As Towner pointed out, "We are in the midst of an epidemic which promises to get a lot worse before it gets better."

The quintessential question is how are we going to pay for the AIDS costs, Dr. Davies says — meaning we, the taxpayers.

The long and short of it is that if the industry shoulders the brunt of the AIDS cost, our premiums are going to increase dearly. And if the government balances the cost on top of an already inflated budget, our taxes will take a hike.

No one has come up with any magical solutions to protect the future of the health-care system. Dr. Wurmbrand sums up: "Do we make the insurance structure share the responsibility or do we let them off the hook and dump it (the cost) on the social welfare system which is already overburdened?"

No matter what choice is made, "There's going to be a gap between what health insurance will pay and what the common person can pay, and the public is going to have to foot that bill," she says. "We're either going to pay for it or we're going to pay for it."

Unfortunately, Dr. Davies concludes, "There's no pot of money to pay for the AIDS problem." OSMA

Deborah Athy is Associate Editor of OHIO Medicine.

OSMA's AIDS Task Force

In June of 1986, under the growing threat of AIDS, the OSMA Council formed an AIDS Task Force, an eight-member group of concerned physicians devoted to addressing the myriad of questions, concerns and issues surrounding AIDS.

The Association chose E. Huxley Miller, MD, to serve as Chairman of the Task Force, and appointed as members Carlos O. Andarsio, MD; Stanley L. Fox, MD; Thomas J. Halpin, MD; James B. Metzger, MD; George A. Nankervis, MD; Jack L. Summers, MD; and Joan Wurmbrand, MD.

In the relatively short time since it was formed, the committee, which meets when a particular concern warrants it, has tackled a number of AIDS-related issues, including the formation of association policy regarding the various aspects of AIDS.

The committee has also reviewed AIDS-related bills and reported its recommendations to the OSMA's Legislative Committee; recommended that *OHIO Medicine* publish the Centers for Disease Control's official AIDS guidelines; and suggested that the Task Force work with the Ohio Department of Health in devising and publishing clinical AIDS guidelines for Ohio health-care workers.

Perhaps one of the biggest accomplishments of the Task Force has been the recent production of "AIDS: Separating Fact From Myth," a patient brochure designed to be distributed in physicians' offices. Apparently, the brochure — which was a joint effort between the Task Force and the OSMA's Department of Communications and Physician Marketing — has been a success: As of January 1988, over 50,000 copies of the pamphlet have been distributed statewide. — Michelle Carlson

AIDS Legislation

A View From the Statehouse

By Michelle J. Carlson

Once thought to afflict mainly male homosexuals and IV drug abusers, we now know that AIDS crosses virtually every sex, race and age barrier. The disease does not discriminate. And, as the threat of AIDS becomes more apparent to the masses, so too do the key issues surrounding the disease: Who should be tested for AIDS? Should testing be mandatory or voluntary? Should a person with AIDS be denied health or life insurance? How and where should AIDS patients be cared for? Who should foot their health-care costs?

While no one claims to have all the answers, Senate Bill 353, the most comprehensive AIDS-related bill ever introduced in the Ohio legislature, attempts to cover the most pertinent issues. Sponsored by Senator David Hobson (R-Springfield), the bill addresses everything from informed consent to the licensing of community homes for AIDS patients.

"This bill is more comprehensive" than previous AIDS-related bills, says Carolyn Towner, Associate Director of the OSMA's Department of Legislation. "If (AIDS legislation) is going to pass, this is going to be the vehicle."



The bill would, among other things, establish counseling and testing programs for groups at risk for contracting the AIDS virus, counseling programs for health-care providers, educational projects for groups at risk, and programs for long-term care of AIDS patients; expand regional outpatient treatment; create a surveillance system for monitoring the number of cases of AIDS in Ohio; and encourage the formation of AIDS task forces in rural and urban communities.

Observes Towner: "I don't think physicians have any problems with the programs included in Senate Bill 353."

There are, however, portions of

the bill that are decidedly more controversial. A section of the bill, for example, requiring informed consent before testing for the AIDS virus has raised concern among more than one physician.

That part of the bill would prohibit any person, state governmental agency or local governmental agency from performing or ordering the performance of an HIV-related test on any person without receiving the informed consent of the person to be tested or his/her legal guardian, except in situations specified in the legislation, such as a medical emergency.

Some physicians are concerned with the informed consent provisions because physicians want to be able to test when they believe it is medically necessary.

As a compromise, the OSMA was able to get the Ohio Department of Health to agree to an amendment that states, in part: "A person who acts in good faith in complying with the informed consent provisions is not liable for damages in any civil action."

"This is a good provision we're getting in," notes Towner. "Our legal counsel is very happy with it because it gives physicians immunity coverage."

Some physicians have also rejected a section of the bill that provides for criminal penalties where violations of informed consent or disclosure of test results occur. The penalties range from a minor misdemeanor for negligent behavior (a \$100 fine) to a second-degree misdemeanor (up to six months in jail and a \$1,000 fine) for knowing or reckless violations of the law.

"We have problems with criminal penalties," says Towner, adding that the OSMA would like to see the provision applied only in cases of reckless behavior. In fact, the OSMA has also been able to get the Ohio Department of Health to agree to an amendment that would remove the criminal penalties for negligent behavior. Unfortunately, the criminal and civil penalties in Senate Bill 353 only apply to health-care providers and health-care workers; the criminal penalties do not apply to insurance companies or to the non-discrimination provisions in the legislation.

While debates over the controversial bill continue to rage, Towner points out that "A lot of the controversy depends on what physician you talk to. Some have no problem with the bill. Our AIDS Task Force voted to support it. Our legislative committee voted to support it. But some still feel that it will not protect the health-care workers."

Physicians should take note that they have awhile yet to discuss the merits — as well as the liabilities — of the proposed legislation. The bill, which is in the Senate Health, Human Services and Aging Committee, has not been voted on in committee and so has not yet reached the floor of the Senate; it is not expected to be acted on until sometime next fall.

At the present time, other amendments to Senate Bill 353 are being discussed, but no amendments have been made to the bill. **OSMA**

A Special Testament



Next month, a special quilt will be placed on exhibit at Cleveland's Civic Center Auditorium. For two days — June 4 and 5 — it will be displayed, then it will be packed up and moved on to other cities, to other auditoriums.

The quilt is not part of some traveling folk art exhibit . . . though it could be, nor is it the product of any single artist-seamstress . . . and yet it is.

The quilt is more formally known as the NAMES project, with its bold, colorful design — and its poignant message.

The NAMES project originated in the San Francisco area as the vision of one individual. Since then, it has evolved into what staff members describe as the nation's largest community arts project. The quilt is comprised of almost 2,000 individual panels, each lovingly designed by a friend or family member of an AIDS victim as a testament to that person's life.

"This quilt is a gift from the hands and hearts of thousands of

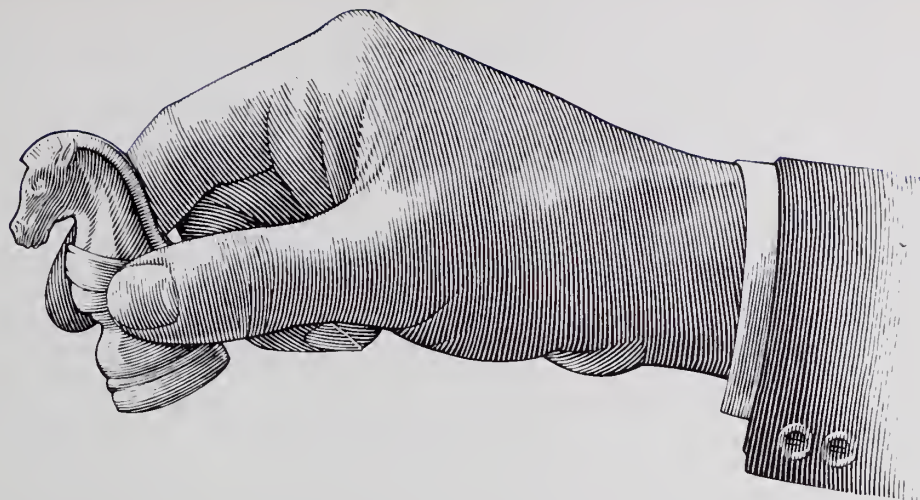
Americans who have not despaired. It stands as a statement of hope and remembrance, a symbol of national unity and a promise of love," writes NAMES project Executive Director Cleve Jones in a brochure that will be available at the exhibition.

The brochure further explains the reason for the quilt and the national tour:

"By displaying the quilt in cities and towns across America, we hope to combat ignorance and fear of AIDS and offer examples of compassion and love instead. When a cure is found and the last piece is sewn into place, the quilt will stand as a national monument — the first such memorial created by those who most closely feel the loss."

Anyone who wishes further information about the quilt — either about other stops on the tour or how to contribute a panel — should contact: the NAMES Project, PO Box 14573, San Francisco, CA 94114, (415) 863-5511. — *Karen S. Edwards*

It's Your Move Doctor...



Getting your message heard in the Statehouse is like a game of chess. It calls for calculated moves, timely strategy and constant evaluation. You may have to take an aggressive stand, or you may have to lay back and wait for your opponent to make the first move.

But unlike chess, the activities representing the views and concerns of Ohio's physicians before the legislature take a team effort. The voices of thousands must be heard to make your elected representatives notice your message. OMPAC, the political action committee of the Ohio State Medical Association, lets you be a part of the team. Your contribution assures that your views, and those of your patients, are considered when government actions affect the practice of medicine and the delivery of quality health care.

Be a part of the OMPAC effort. Our strategy involves every physician in Ohio. Your support is needed to continue the effort to strengthen OMPAC.

Don't be a pawn of the political process. Join OMPAC today.

----- Clip & Mail -----

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Check One:

_____ Yes, I want to be a Sustaining Member of the Ohio Medical Political Action Committee.
Enclosed is my personal payment of \$125.

_____ Better yet, both my spouse and I would like to be Sustaining Members of the Ohio Medical
Political Action Committee. Enclosed is our payment of \$200.

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No Corporate Checks Please.

Make personal checks payable to OMPAC,
or charge your OMPAC membership on your personal MasterCard or Visa.

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Signature _____

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Columbus, OH 43026

OMPAC is a separate segregated fund established by the OSMA. It is connected with AMPAC, a separate segregated fund of the AMA. Voluntary political contributions to OMPAC should be written on personal checks. Contributions are not limited to the suggested amount. Neither AMA, OSMA nor county medical societies will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Voluntary political contributions are subject to the limitations of FEC regulations. This solicitation by OMPAC is not authorized by any candidate or candidate's committee. Contributions to OMPAC and AMPAC are not deductible as charitable contributions for federal income tax purposes.

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. [Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.]

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely.

A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose pre-filled disposable syringes.

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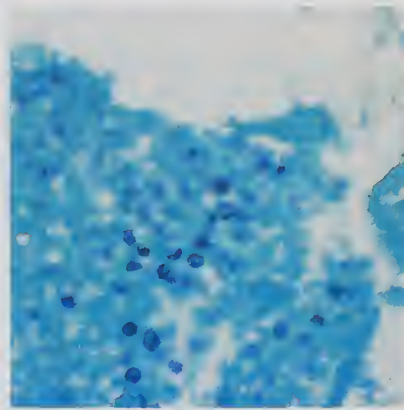
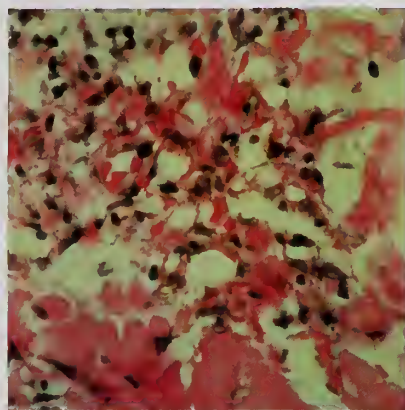
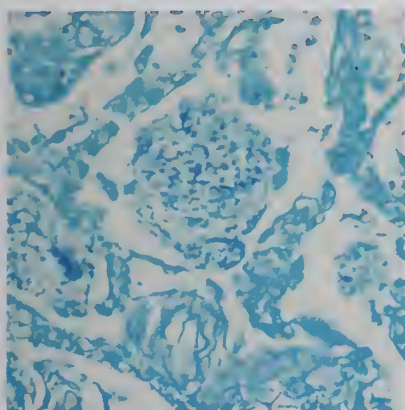
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RESULTS



AIDS Nomenclature: An End to the Confusion?

Over the years since Acquired Immunodeficiency Syndrome (AIDS) was first identified, a great deal of progress has been made. Two causative agents, HIV-1 and HIV-2 have been isolated and identified. Researchers have analyzed the structure and genomes of AIDS-associated viruses, hoping to find vaccines, or drugs that prevent viral replication. The medical literature is rife with discoveries from trailblazers seeking an answer to AIDS.

But for the average clinician, following that trail can be confusing and frustrating. Over the last few years, names such as HIV, HTLV, LAV, ARV and IDAV — with appropriate arabic numerals attached — have reared their ugly heads to confound attempts at understanding.

A simple look at the chronology of AIDS research might make some sense from the confusion.

Between 1980-82, Gallo, Poiesz and co-workers at the National Cancer Institute isolated the first human retroviruses, naming them Human T-cell Leukemia Viruses (HTLV-1 and 2). These viruses were associated with adult T-cell leukemia, and hairy-cell leukemia, respectively.

In 1981, several groups of researchers independently diagnosed a new disease, AIDS, in a group of young homosexual men. In February of 1983, Dr. Gallo of NCI postulated that AIDS was caused by a retrovirus.

But it was a group of French researchers (Barre-Sinoussi, Chermann, Montagnier, and co-workers) who first isolated an

AIDS-causative virus later that year. Because their isolate was associated with a lymphadenopathy syndrome and seemed unrelated to Gallo's HTLV family, Montagnier's group quite naturally called it the Lymphadenopathy Associated Virus (LAV).

In 1984, Gallo's NCI group published results on what was thought to be a different virus: one which they had independently isolated from a different group of AIDS patients. Gallo's group was able to grow large quantities of the virus, allowing them to characterize it and develop an antibody detection test. Moreover, Gallo believed that this virus (though very similar to the Montagnier's LAV) was closely related to the HTLV family which

By William J. Pomidor, MD

his group had identified earlier. Thus came the name HTLV-3.

It was subsequently accepted that the two viruses were similar enough to share a common name, but the dispute between Gallo and Montagnier caused the dual name HTLV-3/LAV to be used until 1986. Additionally, Jay Levy of the University of California in San Francisco isolated a similar, but less closely related AIDS-causing virus, calling it the AIDS-associated retrovirus (ARV). A fourth name, Immunodeficiency Associated Virus (IDAV) was tossed into the fray, compounding confusion even further.

Into the fracas strode Harold Varmus, champion of the International Committee on the Taxonomy of Viruses, chosen to head a subcommittee for the naming of the AIDS viruses. Also part of the group were several AIDS researchers, including Montagnier and Gallo. The two put aside their differences (somewhat reluctantly) when the committee chose the new name Human Immunodeficiency Viruses (HIV) to include those retrovirus believed to cause AIDS.

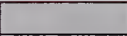
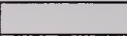
But the controversy wasn't over. Phyllis Kanki, Max Essex, and co-workers at the Harvard School of Public Health discovered a new virus (HTLV-4), possibly associated with AIDS. Nearly simultaneously, Montagnier announced his results: another AIDS isolate, which he termed LAV-2. Over a year passed before it was agreed that the two viruses were of the same type. Because they were unlike the original HIV virus, they were given the name HIV-2.

Consequently, the original AIDS virus is now called HIV-1.

HTLV-5, recently discovered by a group of Italian researchers at the University of Rome will probably remain an HTLV, because it does not appear to be a classic immunodeficiency virus.

A Chronology of AIDS-Associated Acronyms

	1980	1981	1982	1983	1984	1985	1986	1987	1988
HTLV-1									
HTLV-2									
HTLV-3									
HTLV-4									
HTLV-5									
LAV									
LAV-2									
ARV									
IDAV									
HIV									
HIV-1									
HIV-2									

 Name remains the same
 Name changed to HIV-1
 Name changed to HIV-2

And so ends the confusion. For now. OSMA

William J. Pomidor, MD, is placing his medical practice on hold to pursue a career in writing.

REFERENCES

- Coffin, J., Haase, A., Levy, J.A., et al. Human immunodeficiency viruses [letter]. *Science*. 1986;232:697.
- Gallo, R., Montagnier, L. The chronology of AIDS research. *Nature*. 1987; 326:435-436.
- Marx, J.L. New relatives of AIDS virus found. *Science*. 1986;232:157.

Marx, J.L. AIDS virus has a new name — perhaps. *Science*. 1986;232:699-700.

Name game: whither all the HTLVs? [news feature]. *Medical World News*. Feb. 8, 1988:50.

Newmark, P. Variations of AIDS virus relatives. *Nature*. 1987;326:548.

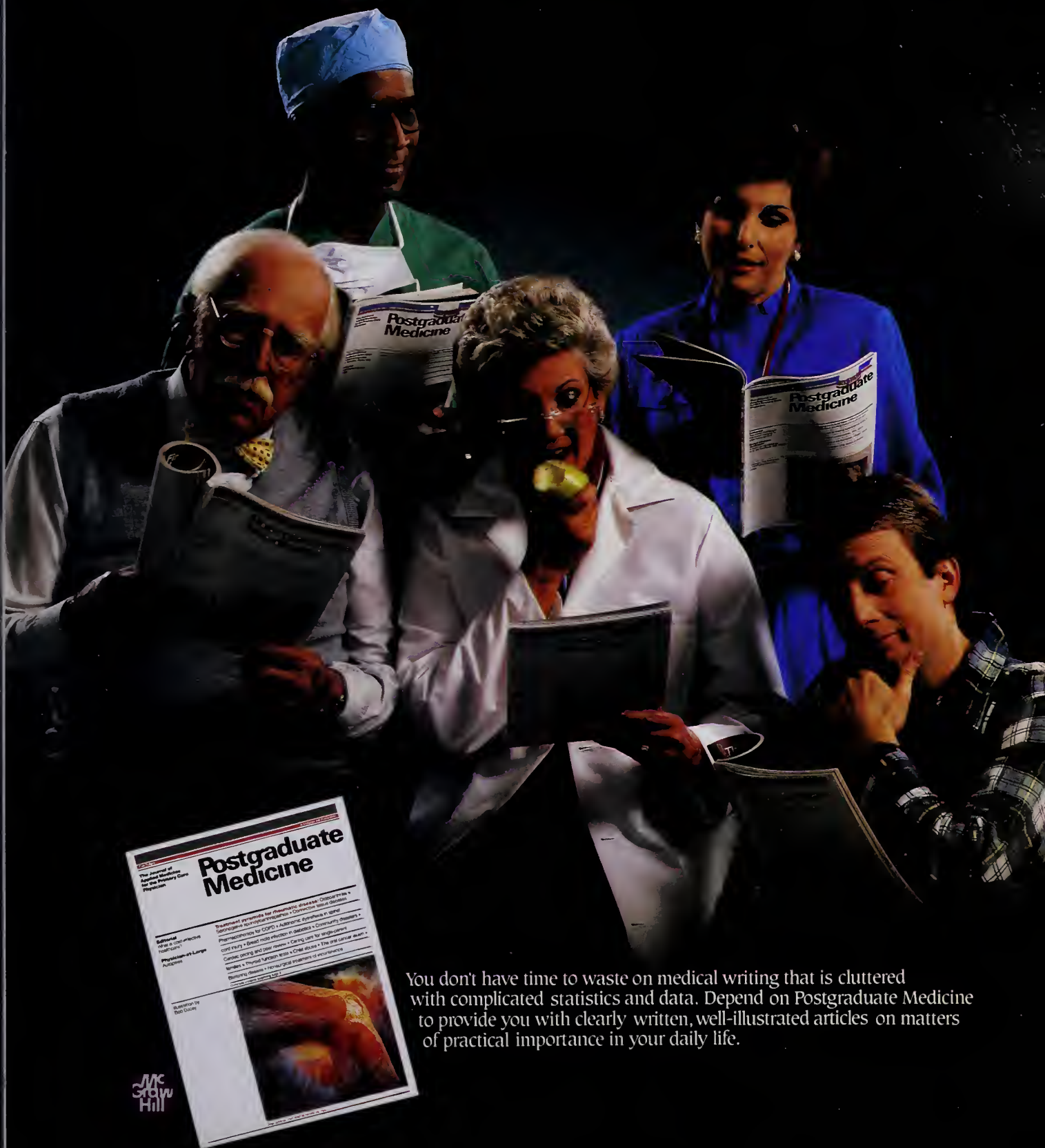
Norman, C. HTLV-III and LAV: similar or identical? *Science*. 1985;230:643.

Norman, C. A new twist in AIDS patent fight. *Science*. 1986;232:308-309.

Palca, J. Controversy over AIDS virus extends to name. *Nature*. 1986;321:3.

What's in a name? [editorial]. *Nature*. 1986;321:2.

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AIDS

Where Will All the Patients Go?

A statewide look at facilities for AIDS patients

By Karen S. Edwards

Last year, 299 Ohioans were diagnosed with the AIDS virus — up from 180 the year before — and still the statistics continue to grow. As they do, however, one problem continues to surface; one question rises to haunt again and again not only those in the medical community, but those in social agencies, religious organizations and the general public as well: “Where will all the patients go?”

AIDS patients who are seriously ill, of course, arrive in hospitals where their opportunistic infections are managed as well as modern-day medicine can possibly manage them. But once these patients are released — then what?

“There is a great need now, and there will be an even greater need in the future, for appropriate services to care for AIDS patients,” says Sally Boales, patient care coordinator with the Ohio Department of Health’s AIDS unit.

The services, she says, are needed to fill a huge gap that presently exists between the acute care offered by hospitals — and no care, the kind most people with AIDS typically face.

AIDS after all, is *not* your usual terminal illness. It remains a disease with a stigma — still the product of a fear and ignorance that created a hysteria about tuberculosis in the 1950s, and about cancer up through and including the present decade.

Today, a pronouncement of TB or cancer is no longer as startling as it once was. Advancements have been made and the medical profession is now able to offer some hope along with the diagnosis.

AIDS, however, is still a medical mystery — and where mysteries exist, so too, does misunderstanding.

As a result, AIDS patients are often left scrambling for services after release from a hospital.

“Home-based services are often difficult for an AIDS patient to obtain, because a caregiver must be on hand, and usually this isn’t possible,” says Boales.

In fact, it’s not unusual for an AIDS patient to be lacking a *home* once the diagnosis is made.

For the past two or three years, then, community AIDS task forces and other groups have looked around for a solution to the problem — something to fill in the gap between no care and acute care.

One of the first ideas to surface arose from a traditional setting — the nursing home.

AIDS patients in nursing homes

“We began talking about receiving AIDS patients in late 1985,” says Don Brezine, an attorney and former Executive Director of Friends Care Center, a nursing home in Yellow Springs, Ohio (and the only Ohio nursing home, at present, which accepts

AIDS patients). He has since left that position for one with a private law practice in Fairborne.

"We discussed the idea with a professional advisory group, and finally started receiving patients in 1986."

The program at Friends Care is limited to two beds — because it is a full geriatric facility, and because it is meant to serve only as a resource for *local* AIDS patients, though Brezine admits that the facility has drawn patients from surrounding communities, including four out-of-state admissions. So far, 12 patients have used the Friends Care program.

"We do feel similar programs should be set up in nursing homes around the state, so that an AIDS patient can go to a nursing home nearby," says Brezine. He is currently working with Boales toward this end — serving as a volunteer consultant to those nursing home administrators who have indicated to the ODH an interest in reserving beds for AIDS patients.

Brezine is adamant about the need.

"It's clear that some AIDS patients will be in nursing homes in the future. We need to be asking ourselves now — can we help this happen in a way that will be more conducive to staff, residents, families, people with AIDS, boards of directors and administrators? We need to think this through *now*, at our own pace, and avoid having to do it when we are at a crisis stage, or faced with a lawsuit."

Brezine's experience has taught him there are both pros and cons with such arrangements — and both need to be given proper attention.

"Will we lose customers if we accept AIDS patients? Will residents accept bringing this social problem into their house, because, to these people, that's what this

facility is — their home," Brezine asks. These questions have the potential to elicit negative responses, yet, there are positives, too, he insists.

"Older people should not be patronized when presented with this issue. They will deal with it," he states confidently — and the give-and-take discussions that are generated as a result will give residents a healthy feeling of self-respect, he adds.

Another advantage of a nursing home setting, says Brezine, is the fact that residents have long ago accepted the facility as a place to die — "and that it's OK to do so," he says. Such a premise is difficult for many AIDS patients to accept but older residents can help AIDS victims come to terms with their death — if only by their own almost-casual acceptance of it.

That's one reason Brezine likes to see interaction between patient and resident — and he says at Friends, such interaction *does* take place. But it didn't always.

When the program was first proposed, there was some initial fear and hesitation — not only from the residents but from their families as well.

"We started with Sally (Boales)'s course — AIDS 101 — to help dispel the myths," Brezine says, and both residents and their families were invited to attend. That helped clear up a lot of fear and misunderstandings, he indicates.

At the same time, the staff, too, received training, as none of them are exempt from caring for AIDS patients.

"They know that when they're hired," Brezine says. Thanks to proper training and education, however, the staff understands where the risks are — and acts accordingly.

Of course, nursing home beds do not come cheap. Presently, a bed at Friends Care Center costs

\$77 a day. Double that for an AIDS patient.

Most bills are paid for privately, although a few have been paid for with Medicaid funds. The community surrounding the home, however, has been enormously supportive, says Brezine and one local foundation has even offered financial assistance to AIDS residents who may not be able to afford all of the costs.

Brezine will be the first to tell you, however, that while the program at Friends Care has been successful, it is, by no means, the only solution to the "fill-in-the-gap" problem.

"AIDS patients are like everyone else," he says. "They don't want to go to a nursing home unless it becomes absolutely necessary for them to do so."

Others, of course, are inclined to agree.

Community Alternative Homes

As a result, in September of last year, a state law went into effect which permitted the licensing of community alternative homes (CAH) for persons suffering from AIDS.

Here was a solution that seemed a little more palatable.

"A community alternative home adapts to different levels of care," explains Boales.

It provides, primarily, personal assistance — i.e. help with errands, laundry, cleaning and meal preparation. If greater assistance (i.e. nursing care) is needed, it can be provided by outside agencies that will come into the facility and provide whatever level of care is needed.

In a sense, then, the CAH is a home substitute — a refuge for those with AIDS who may not have a home to go to.

"If the person with AIDS has a large support system, it's best for them to stay at home," says Hal Swanson, who has worked as a counselor at a community

alternative home in Columbus and now serves as Vice-Chairman of the Avalon Foundation's Board of Trustees (see sidebar story).

The trouble is, a large number of AIDS patients lack that kind of support — and that's where a CAH can fill in nicely.

"There is often a great deal of loneliness with AIDS," Swanson says. "There is a fear of contagion that leaves you desperately isolated."

The CAH, then, not only provides its residents with the kind of physical help they need, but with a sense of community as well — something to edge out that feeling of loneliness.

According to Boales, the concept of community alternative homes has been around for a couple of years, evolving from planning meetings held by an AIDS long-term care task force at the Ohio Department of Health.

The advantages of a CAH, says Boales, is that it can and does fill the acute-care/no-care gap.

"And there is constant supervision and socialization," she points out.

The disadvantage — at least at the present — is that CAHs are still new and experiencing the same growing pains that any young social agency does at the outset.

"Joshua Foundation (in Columbus) has really been the guinea pig in this whole experiment. They were the first ones to try a CAH," says Boales.

Joshua House

According to John Murphy, Joshua's current acting director, the Joshua Foundation has been around since January 9, 1987 — a little shy of one and a half years.

"It feels more like 60, though," Murphy says with a wry laugh.

Joshua began with two houses, located in different sections of Columbus. Each home housed five residents.

Within a year, however,

AIDS Awareness Week: Working together to prevent AIDS

How much do *your* patients know about AIDS? According to a recent Ohio Department of Health (ODH) survey, many Ohioans are still in the dark about some aspects of the disease.

Almost half of the respondents in the survey reported that AIDS can be transmitted by giving blood. Another 20% still believe mosquitoes can spread the AIDS virus, while 33% targeted the drinking glass as a danger zone for AIDS.

Thus the ODH, the Ohio AIDS Coalition and the Ohio Public Health Association (OPHA) designated May 16-20 as AIDS Awareness Week in Ohio. The goal of the weeklong event is to clear up these lingering misconceptions about the disease and to send out accurate information statewide, according to Rachelle Randolph, ODH Health Planning Coordinator of the AIDS Activities Unit.

The ODH survey uncovered some of the gaps in the public's knowledge about AIDS, and AIDS Awareness Week is one way to begin filling in those gaps, she adds.

As ODH Director Ronald Fletcher, MD, recently noted: "What we do now in terms of prevention will help to halt further spread of the disease."

The event will get under way May 16 on the Statehouse lawn in Columbus with AIDS exhibits and welcomes by Governor Celeste and Dr. Fletcher.

"We really want to represent all

sectors of the community" on opening day and throughout the event, including individuals with AIDS, school children, community and religious leaders, health workers and families, Randolph says.

Some of the special activities scheduled for the event include:

- The OPHA/ODH Conference: "Ohio Working Together to Prevent AIDS," featuring national speakers, a National AIDS Network guest, and an AIDS overview.

- Walk for AIDS: "Helping is Healing," sponsored by the ODH and the Ohio AIDS Coalition. The 7-10 mile walk begins and ends at Schiller Park in German Village, Columbus. Individuals can sponsor walkers, and proceeds will fund more AIDS-related events, nutrition programs and work groups.

- The Director's AIDS Services Award Banquet to be held at the Hyatt on Capital Square, Columbus.

- The final event is a memorial service — "for those who have died as well as for those still living," Randolph says.

- She and others hope the 1988 AIDS Awareness Week will shed some light on AIDS for Ohio citizens. As Dr. Fletcher says, "If this deadly disease is to be stopped, it will require the cooperation and commitment of every health-care agency and every citizen in the state."

For more information, call (614) 466-5480. — *Deborah Athy*

problems began to develop — both internally and externally — and by January, they became public.

Stories of poor management and resident unrest began to emerge, while, externally, the city zoning board declared both homes in violation of zoning codes. Then, Joshua ran afoul of Columbus' laws on charitable solicitation.

Joshua closed one of its homes as a result of its troubles. It set up a resident grievance committee, and appointed new management. Now, says Acting Director Murphy, things have finally begun to settle down. Zoning differences have been resolved, and its present facility now houses nine AIDS residents.

"We've set up our own policy and procedures manual," says Murphy, which, he claims, has taken care of most of the problems.

"Joshua Houses have had turbulent times, like any young service organization, but things are more peaceful now. The residents are more content."

He credits this, in part, to a new admissions policy which denies entrance to ARC patients.

"ARC patients do have other services available to them through the Columbus AIDS Task Force," says Murphy, and by restricting Joshua to AIDS-only patients, he says more bed space is available to those who need it — "and we're not duplicating services."

However, Murphy also points to another reason for the new policy.

"Studies really should be done on the behavior differences between patients with AIDS and those with ARC," he comments. He theorizes that all people diagnosed with AIDS or ARC go through the normal grieving procedure when learning of their terminal illness.

"But ARC patients seem to remain in the anger stage. They strike out at everyone and

everything, while AIDS patients seem to have moved beyond their anger to acceptance."

Joshua, however, is still a growing, changing entity, Murphy says. Input from residents is regularly sought at house meetings — and nothing, says Murphy, is permanent.

"We still don't know what we want to be when we grow up," he says. "Right now, we are tied to the community alternative housing concept, and follow those rules and regulations — but that could change if a different, better direction were to be set.

"We're flexible," Murphy says.

Of course, Joshua is not the only CAH in the state — nor the only one with problems, for that matter.

Early last year, Caracole opened in Cincinnati.

Caracole

Caracole derives its unique name from the snail's spiral-shaped shell.

"We wanted to suggest an enclosure," says the Rev. Jane Gurry, the rector of an Episcopal parish in Cincinnati and spokesperson for Caracole.

The home grew out of a feasibility study, launched late in 1986, by the Cincinnati AIDS Task Force. By 1987, Caracole began to accept its first residents, and the home is now at full capacity with four residents. Rev. Gurry assures there are no problems to speak of — but that hasn't always been the case.

"Initially, there were some neighborhood misunderstandings," she says. In fact, residents of the area sought to close the home by bringing up what they believed were variances in zoning regulations.

Rev. Gurry and others with Caracole held meetings with the area's residents to resolve the situation.

"We more clearly defined the

objectives of the home, and did some AIDS education," she recalls.

The neighbors are quieter now. "Some," Rev. Gurry insists, "don't even know we're around."

Still, the sudden negative media attention did not do much to help Caracole's low profile.

"We try to stay away from media attention so our residents' privacy can be maintained," says Rev. Gurry. Now, however, she says her phone rings every time a question arises about AIDS.

"The media has turned me into an instant expert on the subject — and as my kids would say, 'that's a hoot.'"

The Cincinnati facility, however, has been able to avoid some of the problems Joshua experienced, simply because it's a smaller home — and, if new regulations which are presently under study are approved, things will become even less complicated, says Brad Lutz, resident manager at Caracole.

"The new regs would make CAHs with less than six patients less complicated to set up and run," says Lutz. The chief criteria for these homes would be based, primarily, on following local zoning regulations, he says — actually fairly simple qualifications to meet.

Of course, like Joshua, Caracole has its own set of policies and procedures.

"We don't accept ARC patients unless they have a major disability which would require them to need care," says Lutz, "and each resident is required to be under medical supervision."

Since the home is not zoned for skilled nursing care, patients who become seriously ill are usually transported to a hospital.

"But of course, that's the decision of their physician," says Lutz.

Before taking a look at how these facilities are structured and
continued on page 378

The CAH Changeling

Consider the changeling — one child substituted for another.

In many ways, Avalon Concept, a Columbus group recently formed by ex-Joshua House staff members to provide more local housing for AIDS patients, is a changeling — still a child, and, yet, different in many respects from the state's other Community Alternative Homes (CAHs), also in their infancy.

That there *are* differences is not hard to understand. Avalon was born from the turmoil that beset Joshua House (Columbus' and the state's first CAH) in its beginnings. In a sense, the group is a knee-jerk reaction to the growing pains that community alternative homes are *still* experiencing.

"We saw the pitfalls," says Richard A. Tomkins, Avalon founder and Director of Administrative Services for the group.

Yet Tomkins won't argue that Columbus — as well as other Ohio communities — need some type of housing arrangements, especially now that AIDS research grants have been awarded to three Ohio institutions (see "Ohio Medicine" section, *OHIO Medicine*, March, 1988).

"(Those) protocols are bound to draw more people into the area," he says. And while research is fine for notes, one question consistently remains: "What do we do with AIDS patients in the meantime?"

Tomkins isn't convinced that the CAH — as it exists now — is the answer.

"When the state first drew up plans for a CAH, they had two choices. They could go innovative, or follow an established, traditional route. That's the way they decided to go."

As a result, he continues, there are pages and pages of standards

that are turning CAHs into miniature nursing homes — complete with handrails on the bathtub.

"Avalon is creating something different, more innovative," he says — adding that, since "creativity is limited only by our imaginations, we are looking for other ways to offer better health care."

One way, of course, is to tap the source for ideas itself, so Tomkins says patient input will be taken very seriously by the Avalon Concept board. At the same time, however, the board will remain as unobtrusive as possible with respect to their clients' lives.

"We want our clients to feel totally self-autonomous, and we want to avoid those parenting types of situations, where we tell them, 'I know what's best for you.' If some of our clients want to go out and find their own apartments, that's fine with us. They're adults, and we're not running a prison."

What Avalon is running, then, is a "group home" in the loosest sense of the word. Care is provided residents by existing community resources, and paid for with the help of a new Medicaid waiver which puts no eligibility requirements on such services as adult day care, home-delivered meals, homemaker services and respiratory therapy programs.

A Medicaid waiver is also making it possible for Avalon to set up two-bedroom facilities which can make use of 24-hour health-care programs — thus providing residence access to AIDS patients who are very ill.

However, Tomkins notes, hospices are places where one goes to die, so typically no extraordinary lifesaving measures are taken. "Residents are given morphine, prescribed by their doctors for the pain, and there are

people around to hold their hand. Generally, that's all that's done."

Emotional support, however, is an ongoing provision for Avalon residents, and Tomkins talks of a prototype crisis team, being organized by a Columbus community mental health center that will come in and provide care to Avalon residents on an emergency-type basis.

Of course, none of these services comes cheap — nor does the room itself, for that matter — but Tomkins becomes vague when asked about the type of payment required of an Avalon resident.

"There are so many factors to consider, and each case is different. We decide it on an individual basis."

Basically, Avalon is looking for an equitable amount from its residents, Tomkins explains — one that won't confine the client, but which will give the organization enough money to run the homes properly. As with all such facilities, Avalon too is looking for sponsorship — or, at the very least, donations — to help pay expenses.

In the meantime, however, Avalon's board is proceeding as best it can with the plans that have been made and the goals that have been set.

"We are working, now, to try to create a professional advisory committee — doctors who can help us deal with AIDS on a clinical basis."

But none of these plans or goals are locked into place, says Tomkins.

"Nothing about Avalon is carved in stone. We'll change to meet needs. In fact, we're breaking new ground on a daily basis. We encourage ideas from everyone . . . everywhere." — Karen S. Edwards

funded, there are two other CAHs that also must be mentioned. One is already up and running — and one will be soon. Both are located in Cleveland.

Cleveland's new arrivals

The interesting aspect of the two residences under the jurisdiction of the AIDS Housing Council of Cleveland, Inc., is that they are quite different in nature.

Linda Persse, a social worker who voluntarily serves on the Housing Council, says that one facility has been set up for patients — AIDS or ARC — who are able to live independent lives, but who may require assistance with such personal services as homemaking and meal preparation. That home is presently in place, Persse says, and it can accommodate up to three residents (right now, it has two). No nursing care is provided, however — and, in fact, that's the reason for the Council's *second* facility which is not yet off the ground.

This home, once it's opened, will be used by those AIDS patients who are in need of some level of nursing care. The residence has already been located — "It will accommodate four to five persons," Persse says — "but we're looking for a sponsor, or some donations to help run it."

Which leads of course into a discussion of how Ohio's CAHs are being financially supported.

Money needs, money worries

As Brezine has already mentioned, the cost of a nursing home bed for an AIDS patient runs about \$150 a day. Hospital costs for an AIDS patient — from the moment of diagnosis to the moment of expiration — is estimated to be about \$92,000.

"It's only about one-third of that figure, or less to care for a patient in a community alternative home," says Joshua's John Murphy, which makes this

particular style of care the most cost-efficient way of treating AIDS to date.

Richard Tomkins, who has founded the maverick Avalon Foundation in Columbus (see sidebar story) agrees.

"We are trying to keep patients out of hospitals and nursing home settings, not only from an emotional standpoint — it's very hard to be in this kind of setting — but from a cost basis as well. Hospitals are very expensive."

Yet costs still exist in CAHs — however low — and must ultimately be met.

Since state — even national — funding is not currently available, most community alternative homes are supported by private local foundations or groups.

In Cleveland, for example, Health Issue Task Force, a support organization for people with AIDS, provides 90 percent of the funding for the Housing Council's independent facility, and, as Persse has already mentioned:

"We're presently seeking sponsors and donations to aid in the funding of the skilled-care facility."

In Columbus, Joshua House has received a number of private donations, as well as financial contributions from both the Roman Catholic Diocese of Columbus and a local drug supply company. Cincinnati's Caracole is aided largely by donations from local religious organizations — the Episcopal Church, the Jewish Federation of Cincinnati, and the city's archdiocese.

In addition, however, residents of Ohio's CAHs also pay a room and board fee which helps to meet costs. The average charge seems to be 25 percent of a resident's income — though Columbus' Joshua House charges its clients a fee amounting to \$300 per two-bedroom unit or 65 percent of a resident's income. All profess, however, to showing some

flexibility on this point when warranted.

After all, income for an AIDS patient can be tricky. Most AIDS patients are unable to work, so they depend on Social Security checks to keep them financially sound — but at their young age, social security is often difficult to get started.

"We won't throw them out of the house just because their checks haven't started coming yet," says Murphy — and in fact, at Joshua House, donations frequently go toward "scholarship" or room subsidy — helping to make up the difference between the cost of the room and what a patient can pay.

New Medicaid waivers are also helping to cover costs by dropping the eligibility requirements on such services as home-delivered meals and respiratory therapy programs — and the facility and their boards are doing what they can to qualify for other Medicaid funding.

By and large, however, government support for AIDS housing has not been forthcoming, so the community alternative homes continue to concentrate on fund-raising — and volunteer support.

CAH structure

Volunteerism in fact seems to be at the backbone of most CAH facilities. Paid staff members appear to be the exception rather than the rule — and while they *do* exist (usually in the position of "executive director" or "resident manager") it is volunteer help that really keeps the show running.

At Joshua House, for example, Murphy says about 70-80 volunteers help fulfill a number of duties that the paid staff (which includes himself, a live-in resident manager, an administrative staff member and a part-time social worker) have no time for.

Some of Joshua's volunteers are being drawn from the

Josephinum, a theology school in nearby Delaware County, and Murphy has lately started to pair these recruits with a Joshua resident, letting these "teams" coordinate the various volunteer functions at the house — i.e. food, transportation, hands-on care, office help and fund-raising.

At Caracole, Lutz, a paid staff member, says he relies on volunteer help to relieve him of some of his round-the-clock duties.

Of course, all of the boards at these facilities are volunteers as well — many of whom include physicians.

Physician input, in fact, is especially desirable, say CAH experts, since their clinical knowledge can go a long way in helping volunteers and paid staff members alike care for residents.

"AIDS patients often must deal with multiple medications," says Swanson. Frequently, these medications can cause mood swings — but so, too, can AIDS itself. A doctor can help separate one mood swing from the other, advising the staff whether something can and should be done, he notes.

But even professional advice can't always help. Dealing with AIDS patients, especially on a live-in, round-the-clock basis, can be exhausting — even discouraging.

"Dealing with AIDS patients is one uphill crisis after another," claims Swanson.

Beside the mood swings, some AIDS patients contract a degree of dementia, which can be as frustrating for residents as it is for staff. And energy is not usually a strong point for people with AIDS. Consequently, there is little interest in planned group activities.

"We did hold classes in art, drawing, that kind of thing, but residents showed little interest," says Swanson.

"We're as occupied as we want to be," notes a resident of Cincinnati's Caracole. "We're not

planting maypoles out in the backyard, but we find things to do."

The resident mentioned an ongoing gin rummy game — "I'm ahead in points," he boasts — and the TV. Of course, with four residents and just one set, "You learn a real quick lesson in social adjustment," he says with a laugh.

And socialization, as has already been mentioned, is one of the strong points of a CAH.

"We hope we've set up a home which makes our residents comfortable, and gives them a sense of community," says Caracole's Rev. Gurry.

There, at least, a sense of community among residents does seem to exist. One Caracole resident put it this way: "I've been here less than a day, and already I can sense the camaraderie — the love. It feels like home already."

This feeling seems to evolve from a sense of shared experience — and pain. At times, however, says Swanson, the pain can be *too* intense.

"Sometimes, when a resident is seriously ill, the others don't even want to be in the same room — it's a reminder of their own impending death," he says. Yet, it can also be an emotional catharsis, helping the resident to come to terms with his own mortality, he adds.

And as far as *most* CAH staff members are concerned, dying at community alternative homes beats dying anywhere else.

CAH vs. the nursing home

Joshua's John Murphy tells the story of one resident who told him he was afraid of dying alone. "Are you afraid of that here?" Murphy asked the resident. The resident indicated he was not, "but I'm not sure how I would feel if I have to go somewhere else . . ."

Murphy, however, says Joshua probably would *not* send a resident to a nursing home or hospital,

unless they were directed to do so.

"We fill the role of keeping the patient until his death," he says. "Here they are surrounded by friends and people who care."

His experience, too, has shown that residents are not necessarily disturbed by the death of roommates.

"One of our residents has seen five others die, and his roommate, now, is dying. Still, his preference is to be here," says Murphy.

Swanson agrees that homes — even community alternative homes — can be healthier environments (at least psychologically) than those found in hospitals and nursing homes.

"They are less stressful, and research has shown that the less stress an individual has to endure, the stronger that person's immune system" — an important strength for an AIDS patient to have, Swanson points out.

Cleveland's Linda Persse also believes that, psychologically, residents are better off in CAHs than nursing homes.

"It's easier for residents to be with people who are like them. That way, they don't have to deal with people, like nursing home residents or their families, who may not understand them." Besides, she adds, there is another advantage.

"We can set up our own skilled care facilities faster and more inexpensively than most nursing homes can."

There is no question, however, that even *with* the psychological advantages of home-like care — psychological and emotional support for residents is critical.

"AIDS is a death sentence, and naturally, there is the fear of pain and disfigurement to deal with — as well as discrimination from friends, family and the general public," says Swanson.

That's why some facilities, like Columbus' Avalon, make use of existing community mental health

“I’m here because I have no choice. But gradually, the place becomes familiar — like home . . . and the strangers become friends.”

services. Others, like Caracole, have no structured support — “We’re not organized in any formal sense,” says Lutz — “but there is always someone there to listen.”

Joshua House has even been known to bend house rules on occasion to allow a puppy to stay with a resident.

“Why not?” asks Murphy. “These people usually have enough separations to deal with.”

The need for future growth

In fact the *only* problem that CAH experts can presently see with their form of AIDS care is that, sooner or later, there will not be enough such facilities to care for all the patients.

At present, none of them express any problem with accommodating those who need help — but as publicity continues to grow about these facilities, and referrals increase, problems may eventually arise.

“We don’t have a waiting list right now, but we haven’t sought much publicity either,” says Persse. “It’s possible people don’t know we’re out there yet.”

Referrals to the Cleveland facility, as with most of the other CAHs, generally come from hospital social workers — a very few from knowledgeable physicians — but Persse indicates that referrals can come from anyone, including self-referrals.

“We expect to grow,” she says — but slowly.

“We’ll open one house at a time, with higher levels of skilled care, as they’re needed,” she says, adding, “I rather doubt we’ll open one large facility. We’ll probably

stick with a lot of homes housing just a few residents.”

Joshua House is in the opposite position.

“Right now, we have the capacity to house 10 patients — and we’ve almost reached capacity now,” says Murphy. But Joshua is located in an eight-unit apartment building that has the potential to expand to 16 bedrooms. Joshua offices presently occupy the extra space, but Murphy says if the need for shelter becomes great, he will ask the board to relocate offices so additional space will be open to residents — a sort of built-in expansion plan. Still, Murphy seems confident that more Joshua Houses will be needed in the future.

“We just don’t know how many yet because we still don’t know how many people will be affected by AIDS. The incubation period is so long — it’s just hard to tell.”

The fact that AIDS is entering the heterosexual population, reaching women, children, in fact whole families, raises yet another concern. Should facilities be integrated — with everyone living under one roof — or should separate facilities be created for different sexes and age groups?

Sources seem to be split on this issue. Both Swanson and Murphy could envision separate facilities being created in the future, though neither indicated it was necessary to do so at the present.

“We could accept women in our facilities now,” they say.

Cleveland, in fact, already has a woman in residence, Persse says, and she indicates that women and children will most likely continue to be integrated into Cleveland

CAHs as the need grows.

“Separate facilities will probably not be built,” she says.

Rev. Gurry also says Cincinnati facilities are more likely to be integrated than not, but resident manager Lutz brings up one concern that may yet send CAH staff members searching for separate homes.

“The IV drug users who have AIDS have a whole different set of problems. Frankly, we’re not equipped to deal with them,” he notes.

Separate facilities or not, however, the need *is* out there — and it continues to grow. Whether or not AIDS patients will find the nursing homes and the community homes — or even want to stay in them, of course — remains to be seen. Growing pains, after all, can be very uncomfortable.

Still, the community alternative home — like the nursing home — *is* a viable resource for AIDS patients — and the physicians who treat them. They *do* merit closer examination.

One Caracole resident probably sums it up best. When asked if he likes it at Caracole he replied:

“I’m here because I have no choice. I was not permitted to live at home, so it was this or the streets. Of course, no one *likes* a new place at first — it’s unfamiliar and everyone’s a stranger. But gradually, the place becomes familiar, even comfortable — like home. And eventually, the strangers who surround you become friends.”

Karen S. Edwards is Executive Editor of OHIO Medicine.

AIDS Education: Medical Students Respond

By Jonathan C. Reeser

The AMA-MSS National AIDS Education Project began with a one-day training conference on March 12 in Washington, D.C. A total of 160 medical students, representing 116 medical schools, were in attendance. Student participants from Ohio medical schools included: Greg Cammel, MCO; John A. Welshofer and Audrey Ludwig, UC; Deborah Lenart, WSU; and Cindy Chang, Nandita Bhattacharjee and Jonathan Reeser, OSU.

During the morning session, participants heard presentations on the science and epidemiology of AIDS, and heard about model AIDS education programs at Eastern Virginia Medical School, Rush Medical College and the University of Washington. This was followed by a panel discussion by representatives from the National Association of Elementary School Principals, the National Education Association and the National School Board Association. The panel members emphasized communication and cooperation with parents and local school boards as an effective means of overcoming the reluctance of many communities to expose their adolescents to an AIDS curriculum which openly

discusses homosexuality, heterosexuality, IV drug abuse, and which promotes the use of condoms as a preventive measure. During lunch, participants had the opportunity to "network" with students from other medical schools and exchange ideas. Highlights of the afternoon program included training sessions on speaking to adolescents and speaking in public, and an overview of the psychosocial attitudes of teenagers.

The second phase of the AMA-MSS National AIDS Education Project was a training teleconference, broadcast to every medical school. The teleconference provided interested medical students with an overview of the goals of the AMA-MSS AIDS Education Project, and underscored the urgency of this prevention program by featuring an interview with "Dorothy," a teenage IV drug abuser with AIDS. The teleconference also showed film of an actual AIDS presentation to high school students in Norfolk, Virginia by three medical students from Eastern Virginia Medical School. In addition, a panel of AIDS educators and physicians, moderated by Dr. Art Ulene, responded to questions which were

phoned in by students from across the country.

The teleconference served as a superb recruiting tool, and helped generate student interest in the AIDS Education Project. At Ohio State, 30 first- and second-year students have expressed an interest in participating in the program. Once trained in the AIDS prevention curriculum, these student educators will be able to deliver the AIDS prevention message in schools throughout Franklin County. As the program at OSU grows, we hope to be able to expand our target audience to include the undergraduate and graduate communities at Ohio State, youth organizations, church groups, halfway houses and homes for runaways, and juvenile detention centers (as the University of Cincinnati has done with great success).

The message we hope to convey is, by design, simple and straightforward, and it is communicated in language that teenagers understand. The goal of each presentation is threefold: promote the facts, dispel the rumors and promote prevention. Emphasis is placed on identifying and discussing the behaviors which put an individual at risk for AIDS, and on identifying those actions

“We, as medical students and concerned citizens, have a duty to become involved in the right to halt the AIDS epidemic.”

which are risk free. Abstinence from sex and abstinence from IV drug abuse are stressed as the only way one may definitively avoid infection with HIV, and methods that promote safer sex, such as monogamous sexual relationships and the use of a condom during sexual intercourse, are also discussed. Care is taken to ensure that students understand that AIDS cannot be contracted from toilet seats, from pets, or from casual contact with a person with AIDS. In this way we hope not only to modify the risk-taking behaviors of adolescents, but also to alleviate the nearly paranoid fears about AIDS that are so widespread.

Although education may be the only way in which we can currently hope of slowing or even stopping the spread of AIDS, the simple act of transmitting information does not guarantee behavior change — especially among the adolescent population. Clearly the sexual practices and drug abuse habits of this age group are at once biologically driven and socially complex behaviors, and consequently highly resistant to change. In addition, effective long-term protection from HIV infection requires extreme changes in risk-taking behaviors, e.g. not just using a condom occasionally, but using a condom during every sexual encounter from start to finish. It is unreasonable for us to expect that we will make such a dramatic impact on adolescent behavior. However, there is evidence that aggressive education programs do make a difference, as witnessed by the recent dramatic drop in the incidence of STD infections among

homosexual men (the homosexual population was among the first to actively promote education on AIDS prevention). Thus there is reason for optimism. Although we may not eliminate AIDS, perhaps we can slow its spread.

Medical students in Ohio have a tradition of involvement in community outreach and adolescent education programs. The Student-to-Student program, in which medical students teach grade school and high school students about the dangers of smoking, alcohol, drug abuse, etc., was founded by students at MCO and has since spread to every medical school in Ohio by way of the OSMA-MSS. As those of you who have participated in the Student-to-Student program know, teaching adolescents can be both fun and rewarding. Certainly no current health issue is as charged with emotion and potential danger as AIDS. For this reason, and many others that I have tried to elucidate above, I feel that we, as medical students and as concerned citizens, have a duty to become involved in the right to halt the AIDS epidemic. During the recent teleconference, James H. Sammons, MD, Executive Vice President of the AMA, called medical students “our best resource in fighting AIDS.” We can make a difference, and although “the best we can do in AIDS education offers no guarantee of success, to do less invites failure.” **OSMA**

Jonathan C. Reeser is Project Coordinator, AMA/MSS AIDS Education Project, College of Medicine, Ohio State University.

OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

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Focus on the Membership Outreach Program

By Katherine E. Wisse

At the Annual Meeting in May, the delegates and alternates will be asked to participate in OSMA's fourth annual Membership Outreach Program.

The purpose of this program is to ask nonmember physicians to join the OSMA and AMA. In the past three years many nonmembers have joined because of the recruitment efforts of OSMA leadership.

OSMA membership is at an all-time high — over 20,000 physicians, residents and students. The physician members represent over 80 percent of Ohio licensed physicians. OSMA's goal is to increase that percentage so that we have an even stronger voice speaking on behalf of medicine in Ohio.

Dr. Thomas R. Leech, chairman of the OSMA membership committee, will kick off the 1988 Outreach Program at the opening session of the House of Delegates. Nonmember lists will be circulated at the District pre-caucus meetings to give the delegates and alternates the opportunity to select the page of nonmember names they wish to recruit. An Outreach kit containing recruitment procedures and materials as well as membership information will be available at the

Annual Meeting Outreach desk for those who had previously signed up and those who had not done so before.

The top recruiter in this peer-to-peer program will receive a wool blazer. Previous winners of this award are:

Donavin A. Baumgartner, Jr., MD, Cleveland

William T. Paul, MD, Columbus

Claire V. Wolfe, MD, Columbus

The second place award winner will receive a sport jacket. The third place award winner will receive an Outreach plaque. Any doctor who recruits even one member will receive an award.

In 1988, credit toward awards will be given for a nonmember who joins the AMA as well as the OSMA.

As Dr. Leech pointed out, "The importance of a broad OSMA membership base cannot be stressed highly enough." It has been proven that the best approach to a nonmember is physician-to-physician. That is why participation in the Membership Outreach Program is the most effective way to increase OSMA membership.

It is hoped that all delegates and alternates will take advantage of this opportunity to work for the OSMA and its members.



The Department of Membership Development includes (1st row, l. to r.): Charlotte Kourie, Membership Clerk; Katherine Wisse, OSMA Associate Executive Director and Department Director; Beth Bruckelmeyer, Membership Secretary. (2nd row:) Tina Thomas, Administrative Secretary, and Donna Allen, receptionist. The department is responsible for the membership affairs of the association, the direction of all membership campaigns, and serves as a liaison between the OSMA and the AMA for membership information.

By Deborah Athy

Bringing the Olympic Spirit

The thrill of victory, the agony of defeat. Cleveland area physician John Lombardo, MD, knows firsthand the reality of these oft-repeated lines, after spending a month as the chief physician for the 1988 U.S. Winter Olympics Team.

But perhaps he knew a little about this already. As medical director of the Sports Medicine Clinic at the Cleveland Clinic, Dr. Lombardo put in his training for his event just as the athletes did. In addition, he has served as team physician for the Cleveland Cavaliers, the Cleveland State University sports teams, and Chagrin Falls High School.

Dr. Lombardo, of South Russell Village, has also sampled a taste of the really big shows, twice serving as a team physician for national sports festivals and enjoying a stint as U.S. team physician last summer at the World Games in Yugoslavia.

This time around he led a team of four other doctors and five trainers to the now popular cowboy town north of the border, Calgary, Canada. As the bobsleds bopped, the skaters slipped and



Photo courtesy of Calgary Tourist and Convention Center.

the skiers swiveled, swerved and sometimes somersaulted their way down the slopes, Dr. Lombardo and company were there with their black bags of medical wares in

hand.

In order to cover all the events, the medical teams were fairly spread out, says Dr. Lombardo. One clinic was set up in Kenmore



Back to Ohio

for the cross country athletes; another, in Sait for the exhibition athletes; and the other? Back at the doctors' four-bedroom suite at the University of Calgary.

A motel suite dressed up as a doctor's office? It can be done, says Dr. Lombardo. The first bedroom became the sitting room, the treatment area was in the living room, and a spacious common area became the massage room. Three physicians and four trainers worked out of this ready-made clinic.

The medical teams came prepared for just about anything, Dr. Lombardo says. And, if need be, the U.S. physicians also were privy to a fully equipped polyclinic in the village, which was used by those countries without their own medical teams.

Dr. Lombardo's month-in-brief went something like this: Week 1, set up clinics, make contacts. Week 2, process the athletes — 200 of them — give physical exams, discuss medications, regulations, etc., and attend practices. Weeks 3 and 4, the Games! — cover the events.

Because some of the events

kicked off in the early morning, and others kept the Olympic flame burning into the dusk, Olympic days were long days, Dr. Lombardo relates.

The events he primarily covered were speed skating, disabled skiing and freestyle skiing.

For the Americans, the most serious injuries occurred from falls in freestyle skiing — not that surprising for those who had a chance to watch this sport. Also called aerialists, these skiers get momentum by skiing off a ramp in order to do flips, twists and turns in the air, sometimes at heights of several stories.

Unfortunately, two aerialists suffered concussions on the way down from their jumps.

A stroke of bad luck occurred when one of the American downhill skiers fractured her leg when a volunteer slid into her. Another brush with bad luck came on the final night of the skating competition when American skater Caryn Kadavy had to forfeit her turn because of influenza. She was resigned to staying in her room and watching the events on TV.

"The events went smoothly," Dr.

Lombardo reports. "Injuries were few among all the countries." But, unfortunately, there were some tragedies, he continues — an Austrian doctor was killed when he slid into a snow machine, and a hockey player fractured his facial bones.

But considering the number of athletes and the demands of the sports, "We were pretty fortunate in the number of injuries," he says.

Of the town itself, Dr. Lombardo had this to say: "Calgary is gorgeous. It's the kind of place you'd like to go back to once the Olympics are over. It's an extremely friendly town."

During the Olympic days, the village atmosphere was especially unique, for there was a chance of rubbing elbows with some of the athletes in the village. "We'd run into everybody in the village," he says.

Back at the motel suite, the medals were gleaming just a few doors away from Dr. Lombardo and his crew. "We got to know Bonny Warner (bronze medalist in the luge) and Bonnie Blair (speed skating gold medalist) pretty well,"



John Lombardo, MD

he says, "because they stayed just down the hall."

Dr. Lombardo also got acquainted with many of the hockey players after traveling with them during pre-Olympic tours in December, when they faced the Russian hockey team.

After all the early mornings, the late nights, the razzle dazzle, the excitement, the events — was there a highlight? According to Dr. Lombardo, the highlights were the opening and closing ceremonies of the Games.

"The opening and closing tell you what it's all about. All the countries come into the stadium. The opening signals the fact that the Games are starting, and it's inspiring."

And it must have been inspiring to be present when the schoolgirl from Calgary ran up the seemingly endless steps to light the Olympic torch, and when the athletes poured into the stadiums with multicolored coats, flags and flowers.

The closing was also very special, Dr. Lombardo remembers. "It's a lot more fun," he says. "You realize that it's over. There's a little more interaction between the countries, and the athletes themselves are looser."

Now that the Games are behind

him, Dr. Lombardo doesn't really have much time to get loose. He's trying to get back into the Ohio swing of things — not a pace as slow as some might think. It's back to the clinic, back to the basketball courts, and back to Ohio time, which is two hours ahead of slope time.

And although the Summer Olympics aren't too far around the corner, Dr. Lombardo is going to stay put for awhile. "It was a once in a lifetime opportunity," he says — an honor that was, at times, both enjoyable and difficult.

It's time, he says, to step aside and let others share in the Olympic spirit.

Before signing off, we have to ask just one more burning question: Did Dr. Lombardo see the famed East German skater Katerina Witt, who wowed the crowd and the judges with her

finesse in feathers and sequins?

As a matter of fact: "I saw her at the pairs skating during the first week," he says. "She was sitting right at the next table. She's quite a character," he continues. "She really lights up for the camera."

She has qualities that are shared by many of the Olympic athletes — confidence, spirit and pride. "I saw her on the night of the big skating competition. She was looking very confident, very relaxed," he relates. "She was walking, spinning a rose in her hand."

As for Dr. Lombardo, he'll have memories of the XV Winter Olympics to spin and share for a long time to come.

Deborah Athy is Associate Editor of OHIO Medicine.

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Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

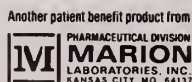
HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Packs of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Issued 1/87

References:

1. Korman MG, Shaw RG, Hansky J, et al. *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al. *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochwil P. *Am J Med* 79 (suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al. *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al. *Gastroenterology* 92:1193-1201, 1987.



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continued on page 395

**Ohio Department
of Health**

**CLINICAL
Guidelines
for
AIDS**

**Printed in cooperation with the
Ohio State Medical Association**

May 1988

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Ohio Department of Health Recommendations for Clinical Management of Individuals with HIV Infection and for Those at Risk for HIV Infection

Physicians need to be effective health educators and counselors to prevent the spread of AIDS. This can best be accomplished by establishing a rapport that enables frank and non-judgmental inquiry into and discussion of the patient's sexual and drug use history.

The goals of these clinical guidelines are:

- 1) To help the physician recognize, evaluate and counsel a person at increased risk for HIV infection.
 - 2) Give a logical approach for HIV testing and interpretation of results.
 - 3) Suggest management options and medical and psychosocial resources for the HIV infected individual.
-

I. INDICATIONS FOR TESTING

HIV testing should never be taken lightly because both positive and negative results can have a serious impact on a person's life. Keep the following questions in mind before testing for HIV.

A. *Who should be tested?*

1. Individuals with known high risk behavior for acquisition of HIV infection may benefit from this test. People at increased risk for HIV infection are:
 - Homosexual and bisexual men
 - Hemophiliacs (primarily those born before 1985)
 - I.V. drug users
 - Prostitutes, especially those who use I.V. drugs
 - Newborn children of parents with AIDS, HIV seropositivity, or at risk for HIV infection.
 - Sex partners of persons with HIV infection or at risk for HIV infection.
 - Health care workers with significant exposure (i.e. deep stick with HIV contaminated needle, cut with HIV contaminated instrument).
 - Any person with signs of unexplained immunodeficiency or with an unusual or aggressive presentation of tuberculosis.

2. Persons who are possibly at increased risk for HIV infection are:

- Individuals who received blood transfusions between 1978-1985, especially if they received multiple units and were transfused in an area of increased prevalence of HIV (example: A leukemic who received 20 units of blood in New York City in 1984).

Individuals not represented in the above list are at low risk for HIV infection and generally should not be tested.

B. *Indications for testing*

The EIA for HIV was originally designed to screen units of blood to create a safer blood supply. It has been quite effective for that purpose but also may be useful for the following reasons:

1. *Diagnosis*

- a) Knowledge of HIV status may help a physician evaluate a patient with signs or symptoms of HIV infection or unexplained immunodeficiency, especially in high risk populations.
- b) A positive HIV test is required for reportable diagnosis of ARC. Documentation of HIV positivity

Table #1: Abbreviations Used in the Guidelines:

HIV	= human immunodeficiency virus formerly classified HTLV-III
PWA	= person with AIDS
ARC	= AIDS Related Complex
EIA	= enzyme immunoassay (also called ELISA)
WB	= Western blot
CDC	= Centers for Disease Control
ODH	= Ohio Department of Health
MMWR	= Morbidity and Mortality Weekly Report

is also required in order for some disorders to meet the CDC AIDS case definition (ref. MMWR, August 14, 1987, Vol. 36, No. 1S).

2. Prevention and education

- a) Knowledge of HIV status, whether positive or negative, may be incentive for some people to change high risk behavior and hence help decrease the possibility of transmission. (example: A seronegative gay male may feel as though he "has a new lease on life" and be more motivated to adhere to the safer sex guidelines.)
- b) It may be useful to define the antibody status of a person who thinks he/she is at risk. There are the "worried well" who, while asymptomatic, may harbor intense anxiety about past high risk behavior and the possibility of infection. Some individuals, while not in a high risk group per se, are uncertain of the activity of past sexual partners. These persons may benefit from knowing their HIV status. In most cases they will test negative and receive peace of mind. However, the physician and patient must be prepared to deal with positive results, the disclosure of which could result in significant depression and suicidal ideation.

A Caveat Related to HIV Testint

In addition to the psychological factors of coping with seropositivity, there are also well documented cases of individuals losing employment and life insurance and suffering various forms of social stigmatization following disclosure of HIV status. Once a result is placed in a medical chart, it is no longer totally confidential, and may be released to insurance companies or employers as part of a general medical release authorized by the patient.

C. Where should the test be performed?

- I. Unless strict confidentiality and appropriate pre- and post-counseling can be guaranteed, the ODH recommends the use of ODH-sponsored counseling and testing sites where testing can be done free of charge, anonymously, and where personal counseling is ensured. For information about the site nearest you, call the Ohio AIDS hotline at 1-800-332-AIDS.

2. Physicians who test from their offices should be:
 - a. Knowledgeable about HIV infection, the tests, and their interpretation.
 - b. Committed to quality pre- and post-test counseling, including initiating a detailed discussion of safe and unsafe sexual practices.
 - c. Able to ensure strict confidentiality among laboratory, nursing and clerical staff.
 - d. Able to obtain the patient's oral or written consent before testing. The patient has the right to decline without being denied health care or medical services.
3. Hemophiliacs should be tested through a hemophilia treatment center. To locate the one nearest you, call the ODH AIDS Hotline at 1-800-332-AIDS.

II. PRE-TEST COUNSELING

THE FOLLOWING SHOULD BE DISCUSSED WITH AN INDIVIDUAL PRIOR TO TESTING.

1. Explain to the individual that there is *NO* "test for AIDS." The test they receive will detect antibodies to HIV, which indicates exposure to and a high probability of ongoing infection with the virus.
2. Ask specifically why the patient desires to be tested. Try to elicit possible high risk behavior so that modifications may be suggested.
3. Educate the patient about the transmission of HIV through exchange of blood or semen, and begin educating him/her on safe sex practices and the danger of needle sharing.
4. Encourage the patient to plan for support from friends, family or a counselor after the results are given. Positive results can cause great emotional distress.

III. TESTS FOR HIV ANTIBODY

Two commonly used tests that detect antibody to HIV include the enzyme immunoassay (EIA) and Western blot (WB). These are sequential tests that are extremely sensitive and specific for the determination of HIV infection.

A. The Enzyme Immunoassay (EIA)

1. Test used to screen blood supply and increasingly as the initial screening test to diagnose HIV infection.

2. Technically easier and less expensive than other tests. (\$10-\$25 for EIA vs. \$35-\$125 for WB)
3. Technique.
 - a. Uses fixed HIV antigen — which is bound by HIV antibody in patient serum to form antibody-antigen complexes.
 - b. The amount of reaction can then be indirectly quantified relative to positive or negative control sera with a spectrophotometer.
4. This test is 99+ % sensitive and 99% specific. The predictive value of a positive result depends on risk status. (i.e. A reactive test in a gay man from New York City has a far greater positive predictive value than a reactive test in a middle-aged white female in Kansas with no risk factors.)

B. Western Blot Test (WB)

1. A test used in conjunction with the EIA, most often as a confirmation test.
2. More expensive and more labor intensive.
3. Technique.
 - a. The specific HIV antigens are separated by electrophoresis and transferred (blotted) onto nitrocellulose paper.
 - b. Strips of HIV antigen-impregnated paper are incubated with a patient's serum.
 - c. Specific banding patterns on the paper indicate HIV Ab-Ag reaction, thus indicating HIV antibody positivity.
4. This test is more specific than EIA but usually less sensitive and more costly. The quality of this test also depends on the laboratory that performs it. Therefore, EIA is the best initial screening test available with WB better for confirmatory testing.

IV. TEST RESULT INTERPRETATION

As in all lab tests, results from the EIA and WB must be interpreted in conjunction with the clinical situation. To interpret HIV test results, first establish the patient's risk behaviors.

A. Test result interpretation for high risk individuals:

1. *Negative EIA.* This is a strong indication that the person has not been infected with the virus. The *exception*, especially in high-risk individuals, is that the person could be in the "window period," a period of time between infection and seroconversion. The generally accepted estimate for seroconversion to occur is 6-12 weeks, and *very* rarely as long as one year. If the patient engaged recently in high risk behavior, he/she should be retested in 3 months. During the period before seroconversion, a person may experience symptoms related to the acute infection with HIV. These "mono-like" symptoms could be a rash, fever, fatigue or other constitutional complaints.
2. *Positive EIA.* A positive result is strongly indicative of HIV infection in a person with a history of high risk behavior. The result should be confirmed by a WB (see below).

Caveat Related to Negative EIA Results:

If a physician receives information indicating values near but below the lowest positive value, he or she may want to retest after 3-6 months as seroconversion may be ongoing.

A WB test could also be run here for confirmatory value.

B. EIA test result interpretation for low risk individuals:

1. Negative — the patient is not infected.
2. Positive or indeterminate — The person's risk status should be reassessed. If he/she is still found to be at low risk of HIV infection, then the EIA should be repeated on another blood sample.
 - a. If a repeated test is negative and the patient has no unexplained illness, he/she can be considered to be non-infected.
 - b. If the repeated EIA is positive or indeterminate, a WB should be performed:
 - 1) If the WB is negative the person should be considered to be non-infected.
 - 2) If the WB is positive the person should be considered to be infected with HIV.
 - 3) If the WB is indeterminate, the person should be considered possibly infected until definitive results are obtained.

Another blood sample should be tested in 6-12 weeks.

V. COUNSELING OF INDIVIDUALS WITH A NEGATIVE TEST SEQUENCE

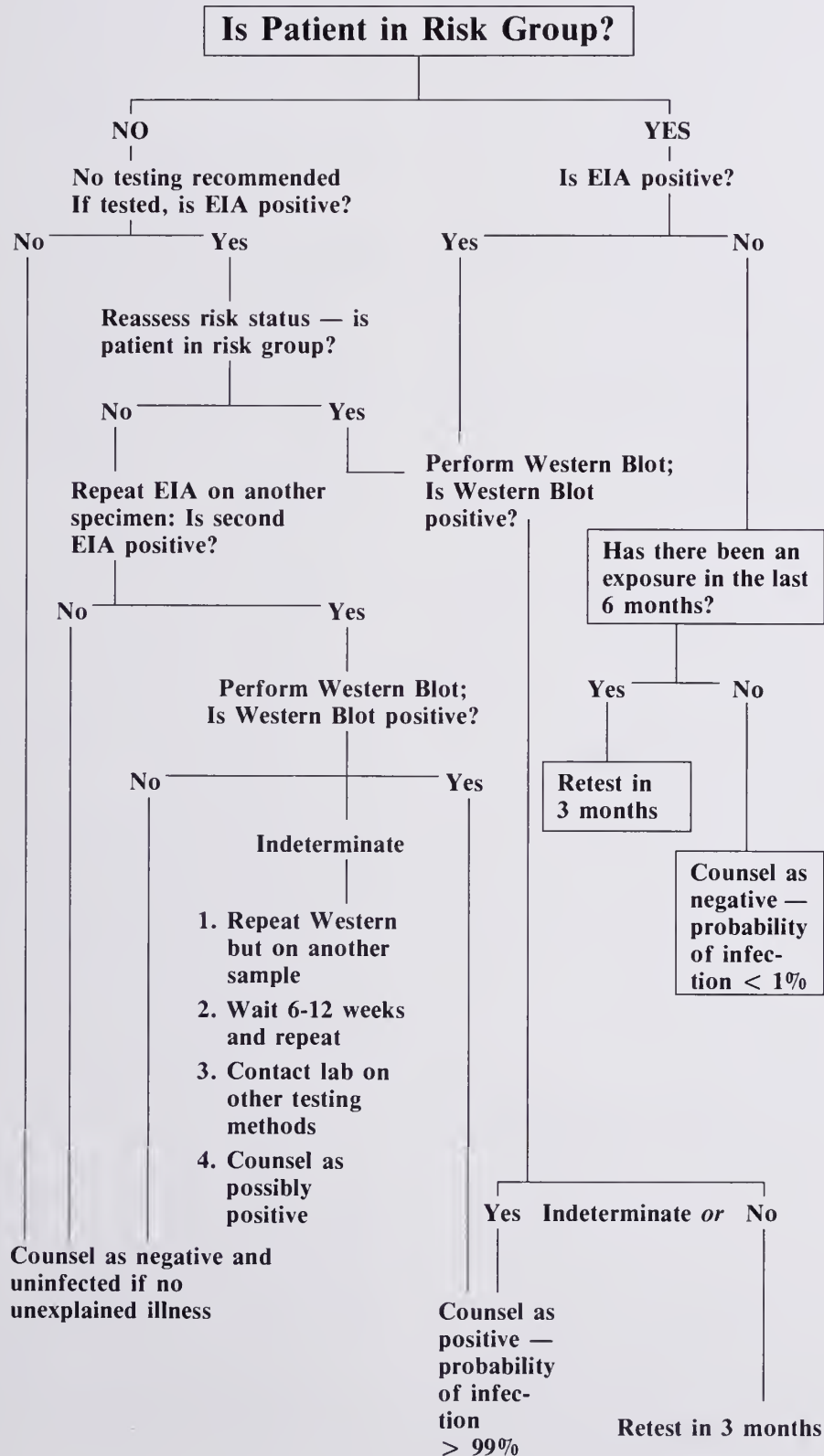
- A. *In low risk individuals:* Reassure them that there is *NO* evidence of HIV infection. Educate them on the modes of transmission, stressing that the true prevalence of HIV in the heterosexual population is not known. Unprotected sexual experiences, even among heterosexuals may be dangerous especially if the past sexual and drug use activity of the sex partners are unknown or high risk.
- B. *In high risk individuals:* Counsel the individual about changing high risk behaviors. This may be the best opportunity a physician has in helping to prevent AIDS. Gay and bisexual males should be informed that it is totally erroneous for them to believe that they are "immune" or know how to pick "safe partners." They should abstain from sex or follow safe sex guidelines, using condoms for all anal-genital, or oral-genital contact. IV drug users should be instructed to **NEVER** share needles and encouraged to undergo drug rehabilitation.

VI. COUNSELING AND INITIAL MANAGEMENT OF PATIENTS WITH POSITIVE WB TESTS

A. Counseling

1. Encourage a full medical assessment.
2. Encourage the patient to inform all past and current sexual or needle-sharing contacts so that these people may seek counseling and testing.
3. Educate about transmission of the virus.
 - a. Even though the individual is asymptomatic he/she can still transmit the virus.
 - b. Casual contact at school, work or home does not transmit the virus.
 - c. Exchange of blood or semen most easily transmits the virus so the patient should not donate blood, plasma, semen or body organs. He should not share needles, razors, toothbrushes, or any other instrument that could transmit blood. The person should abstain from sex or adhere to strict safe sex practices (only after informing potential part-

HIV Testing Algorithm



ners). Safe sex is body massage, hugging, mutual masturbation and closed mouth kissing. Condoms used correctly for anal-genital or oral-genital sex are *possibly* safe.

- d. Women of child bearing age with HIV can transmit the virus perinatally and possibly through breast feeding. Birth control should be recommended.
- e. Vaginal and cervical secretions may transmit HIV during sexual intercourse.
- f. Encourage the patient to inform all medical and dental practitioners to take necessary precautions when performing services requiring possible blood or body fluid exposure.

B. *A complete history should be done focusing on the following symptoms:*

- persistent fever, night sweats, weight loss, memory loss, sensory or motor loss, personality changes, non-productive cough, dyspnea, dysphagia, persistent diarrhea, fatigue or rash.

C. *A complete physical exam should include the following:*

1. The oral cavity should be examined for ulcers, hairy leukoplakia, violaceous macules or papules, and candidiasis.
2. The fundi should be examined for retinal exudates with distinct borders, spreading in a centrifugal manner which may indicate CMV retinitis.
3. Examination of all lymph nodes, liver and spleen should be performed.
4. A total body skin exam for Kaposi's sarcoma, which could appear as red or violaceous macules or papules. Suspicious lesions should be biopsied.
5. A complete neurological examination looking for overt or subtle signs of ataxia, weariness, or other deficit. A mental status evaluation should be done.
6. Genital or pelvic exam and consider culturing for GC and chlamydia.
7. Anal-rectal exam for proctitis, perianal lesions or warts, and other sexually transmitted diseases such as gonorrhea or herpes simplex. Cultures should be considered.

D. *Recommended lab tests for all individuals infected with HIV:*

1. CBC with differential and platelets.
2. Syphilis serology.
3. Pregnancy test if appropriate.
4. Hepatitis B surface antigen and Hepatitis core antibody.
5. Liver function profile (Alkaline phosphatase, SGOT, SGPT, Bilirubin, albumin).
6. Tuberculin skin test with controls to test for anergy. A significant number of persons with HIV infection will be anergic.
7. ABG's and chest X-ray, if any respiratory symptoms are present. The chest X-ray would be helpful if pneumocystis or T.B. is suspected.
8. Further evaluation of any symptom may be necessary to rule out other disease processes.

E. *Suggested Tests (Optional)*

1. T-cell subsets for the absolute number of T-helper cells are helpful in predicting the likelihood of disease pro-

gression. Furthermore, knowledge of a T-helper cell count less than 200 cells/uL in symptomatic and asymptomatic HIV positive individuals allows consideration for therapy with the antiviral medication AZT and may allow entry into other therapeutic trials. Because of the accuracy difficulties in centers where the test is not often performed, the test is most useful when performed and interpreted by an experienced specialist.

2. Toxoplasmosis titer may be helpful if symptoms of toxoplasmosis should develop at a later date.

VII. CLINICAL MANAGEMENT OF A PERSON WITH HIV INFECTION:

The natural history of HIV infection is variable. Many people remain asymptomatic for years, while others develop symptoms sooner. The course may be dependent on some "unknown cofactors." However, data from a seven-year prospective study on gay and bisexual men in San Francisco, suggest an estimate that approximately 31%-35% of those infected will develop AIDS after seven years. Almost half of those studied had at least some generalized symptoms by six years.

The information gained from history, physical and labs will divide seropositive persons into two groups:

A. *Those who are HIV positive without signs and symptoms.*

In addition to close follow-up counseling and referral to support groups the physician can maximize infection prevention by practices such as:

1. Review of vaccination status of routine childhood immunizations and update as appropriate (avoid live virus vaccines such as measles, mumps, rubella and polio).
2. Administration of pneumococcal vaccine and the annual influenza vaccine.
3. Administration of Hepatitis B vaccine if the patient has not had previous or ongoing infection.
4. If a tuberculin skin test is positive, a thorough evaluation for active TB should be undertaken, and isoniazid prophylaxis should begin. The recent sharp increase in TB cases in New York City is probably related to HIV infection. HIV is theorized to help in reactivation of latent TB infections. TB/AIDS cases are especially prevalent in IV drug users and foreign-born HIV-infected individuals. Persons with AIDS and TB are more likely to present with an unusual and aggressive form of TB with increased involvement of extrapulmonary sites. Patients may present with infiltrates in any lung zone, which are often associated with hilar adenopathy. They also exhibit increased side effects and resistance to the usual drug therapy for Tuberculosis.

B. *HIV positive with symptoms or signs.*

There are many complications of HIV infection, some of which are caused by the virus directly and others which are secondary to the resulting immunodeficiency and opportunistic infections. These patients may require extensive medical evaluation. Some will fall into the diagnostic category of AIDS or ARC (both of which are reportable in Ohio). Others may be symptomatic without

falling into any diagnostic category. Reporting forms are available from the ODH AIDS Unit (614) 466-5480 or the Infection Control Practitioner in any local hospital and from local health departments. For those whose evaluation indicates the possibility of AIDS or ARC, one may elect to consult or refer the patient to a specialist in AIDS or infectious diseases. A list of medical, social and psychosocial services and providers in your area is available by calling the toll-free AIDS hotline 1-800-332-AIDS.

1. ARC

A diagnosis of ARC is defined by the ODH as a positive HIV serology plus three or more of the following clinical signs or symptoms present for at least three months.

- a) Fever > 100 F.
- b) Lymphadenopathy at more than two extralingual sites. (Lymphadenopathy may also be a result of other diseases such as EBV, CMV, toxoplasmosis or lymphoma.)
- c) Diarrhea (intermittent or constant) — other pathogens may be present such as Giardia, Entamoeba or Cryptosporidia and should be identified.
- d) Fatigue — to the point of decreased mental or physical function.
- e) Night sweats — (intermittent or continuous)
- f) Idiopathic Thrombocytopenic Purpura.
- g) Oral candidiasis.
- h) Weight loss of up to 10%.

2. AIDS

a. Case Definition

The case definition of AIDS is clearly outlined by the CDC (MMWR, August 14, 1987, Vol. 36, No. 15). Briefly, a diagnosis of AIDS is appropriate if a patient has any of a list of "indicator diseases" of three basic classes: 1) opportunistic infections; 2) opportunistic or peculiar neoplasms; 3) other syndromes directly related to HIV infection (examples: HIV dementia, HIV wasting syndrome). A positive HIV test is needed for making the diagnosis if it is based on one of the HIV related syndromes or if an opportunistic infection or malignancy has not been diagnosed definitely. The criteria for making a "presumptive" vs. a "definitive" diagnosis is outlined in the CDC guidelines.

b) Common AIDS-related opportunistic infections, neoplasms or syndromes.

- 1) *Pneumocystis carinii* pneumonia (PCP) is the most common opportunistic infection causing death in PWAs. It is characterized by gradual or abrupt onset of dyspnea, a nonproductive cough, and a diffuse bilateral interstitial pattern on chest X-ray. Other causes of an interstitial pneumonitis are CMV and mycobacterial infections.
- 2) Esophageal candidiasis is characterized by retrosternal discomfort when swallowing. It may or may not be associated with oral candidiasis or thrush.

3) Mycobacterial infections of all types are commonly seen in AIDS. The *M. avium* complex is one of the most frequent opportunistic infections and is associated with numerous non-specific symptoms such as fever, weight loss, diarrhea and malabsorption. It is important to distinguish *M. avium* from *M. tuberculosis* because of differences in therapy and the public health implications of *M. tuberculosis*.

4) Kaposi's sarcoma, the most common neoplasm in AIDS, appears as dark red or violaceous macules, plaques or nodules, or even trivial appearing patches. Lesions can also develop in nearly all internal organs.

5) Neurologic symptoms are present in a majority of PWA's. Some of these symptoms are a result of opportunistic infections of the CNS, such as toxoplasmosis or cryptococcosis, or are a result of CNS lymphomas. In addition, because HIV is neurotropic, direct viral involvement of the central or peripheral nervous system can occur. One example is subacute encephalitis, also called the AIDS dementia complex, which is eventually seen in a majority of PWAs. It is characterized by a progressive decline, over weeks to months, in cognitive, motor, and/or behavioral functions. When the disability interferes with occupation or activities of daily living in an HIV positive person, then a diagnosis of AIDS can be made. On occasion the dementia has progressed to psychosis or other changes in personality which has made long-term care for these persons difficult.

6) HIV wasting syndrome is another clinical diagnosis (like HIV dementia) added to the revised CDC definition of AIDS. The patient must also be serologically positive for this diagnosis. It is defined as findings of profound involuntary weight loss (>10% of body weight) and either chronic diarrhea (at least two loose stools per day for 30 or more days) or chronic weakness and documented fever (for greater than 30 days or more on an intermittent or chronic basis) in the absence of concurrent illness.

VIII. THERAPY OF PERSONS WITH SYMPTOMATIC HIV INFECTIONS INCLUDING AIDS/ARC.

- A. Infection control with appropriate vaccination as in the asymptomatic HIV positive patient (sec. VII A, above).
- B. Treatment of opportunistic infections is continuously changing and beyond the scope of this article (refer to a specialist).
- C. Antivirals — the first HIV antiviral to receive FDA approval is Azidothymidine (AZT) and marketed as Retrovir. It is approved for persons with AIDS or ARC, but any HIV positive individual who is symptomatic and with a low T-helper cell count may be considered for therapy. AZT was shown in one study to be effective in prolonging survival and decreasing the frequency of opportunistic infections. Its major toxicity is bone mar-

row suppression with anemia and leukopenia (CBC's should be monitored frequently). Acetaminophen is contraindicated for anyone taking Retrovir because it can worsen AZT's hematologic toxicity.

IX. FAMILY AND HOME CARE ISSUES.

A. Social Support Issues.

Many PWAs or persons with ARC do not have strong social support systems. This is especially true for IV drug users but also for many gay and bisexual men. Many family members reject their gay relatives because of their disease or sexual orientation. PWA's are frequently cared for, therefore, by lovers, friends or volunteers. Their caregivers should be aware of the following:

Since there is no evidence of transmission of HIV by casual contact, touching, hugging or massaging the PWA is safe and encouraged. Call the Ohio AIDS Hotline (1-800-332-AIDS) for support resources.

B. General Precautions for Caregivers.

Gloves need not be worn to touch intact skin or clothing that has not been soiled.

Disposable gloves should be worn when contact with blood, semen, vaginal/cervical secretions, feces, vomitus or urine is anticipated. A bleach solution (1/10 dilution in water) is an excellent disinfectant for cleaning contaminated surfaces or spills.

C. Household Hazards for AIDS/ARC Patient.

Possible household hazards that the AIDS/ARC patient should avoid are:

- 1) Pets — the PWA should not clean bird cages, cat litter boxes or fish tanks. Cat excrement can contain toxoplasma. Birds can carry psittacosis and fish tanks may harbor mycobacterial organisms.
- 2) Refrigerators and bathrooms should be cleaned with soap and water to control mold growth.
- 3) Fresh fruits and vegetables should be thoroughly washed and peeled because fungi may be present on their surfaces.

X. FINANCIAL ISSUES

Medical care and treatment for a PWA can be a financial burden. Local resources such as an AIDS task force (call the Ohio hotline at 1-800-332-AIDS for a list) or other community groups may be able to help in alleviating a portion of the burden. The following is a description of some federally funded programs:

- A. All low income PWAs in Ohio are eligible for immediate financial assistance through SSI and Medicaid programs. PWA's may receive SSI payments for up to three months and may qualify for immediate health care benefits under the Medicaid program without waiting.
- B. ARC patients are eligible for Medicaid if they are determined to be "disabled" by their physician.
- C. Ohio has a Medicaid waiver that will allow reimbursement of home and community based services for eligible PWAs and persons with ARC who meet the eligibility criterion. For more information contact the hospital social worker or the Ohio Department of Human Services, Bureau of Community Services (614) 466-6742.
- D. Those PWAs and people with ARC who are candidates for AZT therapy, have a low income, and are not covered by Medicaid or other third-party payers are eligible for funds to pay the cost of this medication. Turn around time for application is one week. Patients may use this resource while waiting for Medicaid reimbursement. Physicians should call, on behalf of their patients, the Ohio Department of Human Services, Bureau of Medicaid Policy 1-800-282-1190 ext. 6420.

XI. REPORTING AIDS AND ARC

- A. AIDS and ARC are legally reportable conditions in Ohio. The physician making the diagnosis is ultimately responsible for reporting cases to the local Health Department, which will in turn forward the report to the Ohio Department of Health. *Every effort must be made at each step of the reporting process to protect the patient's confidentiality.*
- B. For more information about reporting requirements and appropriate forms, contact your local Health Department or the ODH AIDS Unit (614) 466-5480.

Table #2: RESOURCE DIRECTORY

- | | |
|--|-----------------------|
| 1) ODH-Sponsored HIV Counseling and Testing Sites | <i>1-800-332-AIDS</i> |
| 2) AIDS/ARC Reporting Criterion and Forms — Call local health department or ODH AIDS Unit | <i>1-614-466-5480</i> |
| 3) Medical and Psychosocial Resources for HIV positive individuals and those with AIDS/ARC throughout Ohio | <i>1-800-332-AIDS</i> |
| 4) Medicaid Waiver Information for eligible persons with AIDS/ARC — Ohio Department of Human Services, Bureau of Community Affairs | <i>1-614-466-6742</i> |
| 5) Reimbursement for low-income, non-insured AZT recipients — Ohio Department of Human Services, Bureau of Medicaid Policy | <i>1-800-282-1190</i> |

Impressions

of the AMA Leadership Conference

By Cindy Smith

The scene: Salons II and III, the seventh floor of the Chicago Marriott Hotel, February 12, 1988, 5:30 p.m. The room is filled with many of the 400+ participants in the 1988 AMA National Leadership Conference "Strategies for Success." We are gathered for the opening session of the conference. Many who are here have been leaders in organized medicine for many years, some have decades of leadership experience. The majority have enviable titles: Member, AMA Board of Trustees; President, State Medical Association; Delegate to the AMA; President, County Medical Society, and the list goes on. We are here to talk about change, to talk about the future of medicine and strategies for successfully negotiating that future. Yet, in this room, the strength of medicine's past and of the collective experience of those whose eyes have seen the significant changes in medicine in the last 30 years is palpable.

The speaker: Nancy K. Austin, co-author of "A Passion for Excellence: The Leadership Difference." She is talking about the need for "monomaniacs with a

mission" in medicine's leadership. The opening session began an hour ago with a multi-image presentation, "A Tribute to American Medicine," which was an amazing journey at top speed through 200 years of medical history. I wonder, haven't the proponents of change always been "monomaniacs?" Ms. Austin suggests that we devote 50 percent of our work time to our "mission," whatever our particular mission is, and that gradually those who work for us and with us will recognize that our "mission" is our highest priority. I suspect that Watson and Crick spent 50 percent of their time on their "mission" and that Dr. Salk spent 50 percent of his time on his "mission" — perhaps even more time than that. She also talked about "hustle" as a strategy. Today's medical climate demands a willingness to change, an ability to be flexible in order to survive. A pilot study produces more information than a report so she advocates *doing* rather than studying. The climate is changing so fast that to try a new idea on a small scale is more effective than doing a feasibility study.

The topic of our time: AIDS:

Strategies for Action. It is Saturday morning and the day begins with a nose dive into the icy waters of the AIDS epidemic. As of February 1, 1988 there have been 52,256 confirmed cases of AIDS. Ninety percent of those cases are persons in a high risk category, 4 percent are heterosexuals and 789 are children under 13. Over 29,000 people have died. There are significant questions about AIDS that we need answers for: How many people have been infected? What percent of those who are seropositive will eventually become active AIDS cases? Is the heterosexual spread of AIDS stable? Dr. Roy Schwarz, Chairman of the AMA's AIDS Task Force, believes that organized medicine can provide leadership in the areas of AIDS prevention, research, health care, professional ethics, public policy formation and in promoting an attitude of optimism versus fear. Statistics from a recent survey show that 66 percent of the American public would not use the same bathroom as someone with AIDS, 69 percent believe that kissing causes AIDS and 40 percent would be concerned about

eating in the same cafeteria as someone with AIDS. Medical leaders must step up educational efforts in our schools and communities to limit unreasonable fears about AIDS. James Mason, MD, Director, Centers for Disease Control, believes that our strategies for action must be built on the principal that AIDS is here to stay. A technological answer is not in sight and we must, as Dr. Mason says, "Collectively build a structure for a long-term effort." All of the participants in the AIDS discussion stressed that physicians and our society as a whole must provide care for all AIDS patients. Members of the AMA Council on Ethical and Judicial Affairs clarified the responsibilities of the individual physician toward AIDS patients in a workshop entitled "Ethical Issues in the '80s." The Council unequivocally stated that it is unethical for a physician to refuse to treat a patient because that patient has AIDS. The Council also states that it is unethical for a physician who has AIDS to continue to do invasive procedures.

The Debate: Saturday afternoon opens with a forum entitled "Trends in Quality Assessment and Assurance," which seems like an innocuous title but one of the panelists is William Roper, MD, Administrator of the Health Care Financing Administration (HCFA). Dr. Roper fielded many questions concerning HCFA's publication of mortality statistics of hospitals. Dr. Roper agreed that producing mortality rates for hospitals was less than perfect but that it did serve a purpose as a screening device for patients. Conference participants seemed less than satisfied with his response.

The Workshops: The conference provided several excellent workshops Saturday and Sunday with optional workshops for those participants arriving early on

Medical Student Section Update

Congratulations to Bob Mott who received this year's Ohio Public Images' "Award of Merit in the Category of General Awards: In Depth Story or Feature" for his article on medical students working with people with developmental disabilities that appeared in the November issue of *OHIO Medicine*. Bob is a second-year medical student at Wright State University who has done considerable work with people with developmental disabilities in the last two years. Six Ohio medical students

attended the 1988 AMA National Leadership Conference in Chicago. Attending were: John Hughes, Audrey Ludwig, Michael Lucherini, Larry Frick, Cindy Smith and Crystal Higdon. Students interested in the National Leadership Conference should contact one of them.

The OSMA-MSS held its annual meeting on February 27 in Columbus. Details about election results and business items addressed in that meeting will be published in a future issue of *OHIO Medicine*. —
Cindy Smith

Friday. On Saturday I attended the Adolescent Mental Health Workshop and Strategies for Success: Creating Health Policy in the Courts. In the Mental Health Workshop, Carl Bell, MD, the Executive Director of the Community Mental Health Council of Chicago, addressed the fact that when a person who has attempted suicide comes into our hospitals or even our offices, we call out a huge support network of social workers, psychologists, psychiatrists, etc. Yet, when a person has been knifed or has obviously been the victim of domestic violence we very often let them go after "fixing" them physically without counseling about violence. He argues that this silence about violence is an implicit acceptance of the violence. In "Creating Health Policy in the Courts" two lawyers who work for the AMA discussed how the AMA chooses which court cases to become involved in as well as some specific cases that the AMA has recently been involved in. The workshop included an excellent publication entitled "Creating Health Policy in the Courts: The Efforts of the American Medical

Association 1985-1988," which should be available from the AMA.

Other workshops were MAC Marketing Strategies, Service to the Elderly, Community Outreach Strategies, Research Animals Controversy, The Nursing Shortage, Professional Liability, The Health Care Quality Improvement Act of 1986, Challenges to Physician Prescribing Prerogatives, Ethical Issues in the '80s and Legislative Strategies. Cassette tapes of all of the workshops as well as the general sessions are available from the AMA and the quality of the workshops was excellent.

Other impressions: I asked Oscar Clarke, MD, recently appointed to the AMA Council on Ethical and Judicial Affairs, to share some of his impressions of the conference. He said that he felt there was a need to alert leadership about the change of pace in medicine. Dr. Clarke said, "We have to be adaptable to the future. We have an old concept that good, long-range planning works but now we need hustle. We need to be entrepreneurs and

continued on page 405



High Technology and Medicine:

Selected Spin-offs of the Space Program

By Kim Goldenberg, MD

Space — the final frontier, captures our imagination and our longing for exploration and challenge. Over 25 years ago a group of scientists began to design and test the lunar lander for its ultimate destiny in 1969. The combined talents of many people in universities, industry and federal agencies contributed to the success of a mission in research and development many scientists considered impossible. Faced with the spectacular successes and failures of the space program, its major impact on medical technology and practice is not usually apparent.

One of the greatest similarities

between the space program and modern medicine is in biotelemetry in which signals of vital body functions are monitored at a distance. Standing at the display panels of a modern coronary care unit is like standing at the display panels of Mission Control and feeling the excitement before a launch. Technologic advances in electronic monitoring, feedback and control are seen in the pulse generator derivatives of miniaturized space circuitry. For example, implantable defibrillators for treating patients with ventricular tachycardia and fibrillation are in the implementation and refinement phases. These small systems can

contain an audio speaker, a counting mechanism to determine the number of electroshocks, and telemetry capable of reaching an external receiver for physician analysis.

Monitoring is also necessary to follow the heart rate of astronauts on long trips. Since normal hospital electrodes require paste that may dry, it became necessary to develop insulated electrodes which were not affected by ambient conditions of cold, heat, body perspiration and dry or oily skin. Devices now exist that can be worn on the wrist with little concern for environmental conditions or body motion.

Advances in telemetry have also been applied in the area of slow transmission scanning for use in remote stations by paramedics or in rural hospitals. For example, visual transmissions of CT and nuclear scans, ultrasonic imaging, electrocardiograms, or live views of the patient can be transmitted by slow audio signals over telephone lines at operating costs slightly above a routine call (in addition to the original capital investment). Another advance, in radiology, that has evolved from satellite technology is the development of a low intensity X-ray imaging scope (lixiscope). This device is a battery powered fluoroscope which uses radioactive isotope imaging to produce an instant image at less than 1% of the radiation exposure of a conventional X-ray. It has been used in emergencies by paramedics, dentists and orthopedic surgeons. Additional advances from satellite technology, such as advanced image processing systems, include computer-enhanced angiography, nuclear magnetic resonance, and ultrasonics with multispectral imaging. Ultrasound technology is also being developed to determine burn depth, differentiate between

necrotic and viable tissue, and measure intracranial pressure for shifts in acoustical properties that occur with pressure changes.

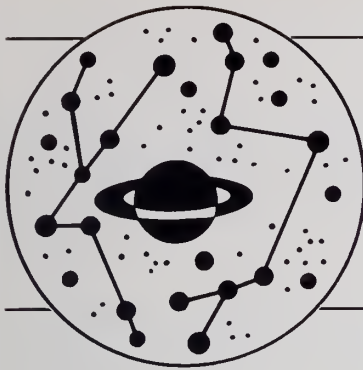
There has also been a rapid technologic evolution in the field of programmable pacemakers. Early pacers were hybrid circuits developed with short-lived, heavy batteries consisting of mercury and zinc. In 1969, the concept of rechargeable batteries was applied to electromagnetic transmission through intact skin. In 1973, single cell nickel-cadmium batteries, like those used in most United States satellites, were inserted into rechargeable pacemakers; today, lithium electrochemistry allows high energy density and low discharge rates to be used in present pacer systems. In 1979, by using instrumentation developed for information coding to unmanned satellites, programmable pacemakers with two-way communications were developed; today, pacers can sense and stimulate both chambers of the heart with almost any desired frequency.

In cardiology education, adjuncts to bedside teaching have been developed that use sophisticated display modules originally developed for the space program. For example, a cardiology mannequin can simulate and display multiple cardiac functions such as a variety of synchronized bilateral arterial and jugular venous pulsations, precordial movements, blood pressures, respirations, and auscultations of the four cardiac acoustic areas of the chest.

A major area of high technology transfer into medicine involves rehabilitation bioengineering. Modern space age materials using high strength and low weight composites have considerably lightened wheelchairs for the over one million people in the United States who rely on

wheelchairs to augment their freedom. Understanding the uses and limitations of rehabilitation and physical therapy has been made possible by sophisticated gait analysis similar to the developments used in satellites for multichannel transmission systems (and for the filtering of electronic noise). Perhaps one of the most exciting areas of research and development is functional electrical stimulation (FES), in which muscles contract in response to electrical stimulation, a concept originally proposed by Galvani in 1790. Space age packaging and electronically reliable technology have been important in minimizing the bulky apparatus that often goes with FES equipment. Astronauts in the 1970's who drove the lunar rover to explore the surface of the moon used one hand to steer, accelerate and brake. A similar device, called the unistik, has been developed for use in a van, and has been useful for quadraplegic patients who have suffered lesions of the spinal cord at the fifth cervical vertebra. This improvement is one of the best examples of coordinated teamwork between academic institutions, federal agencies and private industry.

Diverse areas of biomedical application also include neuromuscular human tissue stimulators for pain control which employ implantable elements the size of a deck of cards. Visual accommodation systems have been developed for eye tracking and stabilized laser photocoagulation. Blood bank transfer processes for aseptic fluid transportation have been derived from sterilization procedures used for spacecraft prior to launch. Since, during flight, the measurement of pathologic specimens had to be both accurate and simple, devices have evolved which included a portable rapid electrolyte analyzer,



Additional advances from satellite technology include computer-enhanced angiography, nuclear magnetic resonance, and ultrasonics with multispectral imaging.

liquid-cooled garments with application to neonatal cooling during surgery, and microtechniques for the direct immunologic labeling of living cells with the potential of separating malignant from non-malignant healthy cells.

Speech, hearing and vision have been an important area of collaborative research. Synthesized speech, as a means of warning pilots of dangerous situations, has led to a versatile portable speech prosthesis which can be used for nonspeaking people and can be placed on a wheelchair. This area is being studied to help some of the one million seriously speech-impaired persons in the United States. Similarly, some of the 1.8 million deaf people in the United States may someday benefit from a speech prosthesis derived from visual cues combined with lip reading. This technology has been developed in part from a metal oxide, silicon (low power electronics), used in space missions. Advances in the area of vision include an ocular screening system to measure retinal reflex for refractive error, retinal and interior chamber defects, as well as corneal obstruction. Pilot studies have been applied to the screening of young children for early eye defects, including amblyopia, ways of measuring the mirrored surface of a telescope by aerospace technology are being used to map the cornea by what is called the corneal optical

topographic scan system. Since the precise shape of the cornea can be obtained by a laser beam which scans the eye, this may prove useful to the corneal surgeon in establishing the cut pattern for keratotomy and in corneal transplantation to estimate suture stretching.

One of the more complex potential uses of technology, a use which derives from small satellite astronomy and telemetry systems, includes programmable implantable medication systems. This area of research may help over one million diabetics in the United States who depend on daily insulin injections by its simulation of the blood sugar sensing and insulin delivery system of the human pancreas. Similarly, the sophistication of sensor-actuated medication systems (which has yet to be perfected) may also be applied to hypertension. A closed-loop control system with an implantable device that releases antihypertensive medication might improve blood pressure control and therefore decrease the complications of hypertension. Most of the above devices would seem incompatible with the human immune system. Pure carbon, however, designed initially for heat shields on space capsules, is lightweight, of appropriate strength, and highly biocompatible so it could be used with these devices.

Other potential contributions of aerospace technology to

implantable devices includes vascular access devices. Patients with kidney disease may ultimately use an electron propulsion program to help texture the hundreds of micropores in percutaneous connectors. Another surgically implantable device is a prosthetic urinary sphincter which can maintain continence in the large number of patients affected by a loss of sphincter control. This device uses valves that are highly reliable with minimal leakage and pressure derived from systems used on the Viking spacecraft. Finally, on a more mundane level, ingestible toothpaste used on flight missions is available for nursing homes. This toothpaste has no air bubbles and, therefore, reduces the chance of choking in those individuals who are predisposed such as patients in nursing homes, paraplegics, the mentally handicapped, and patients with orofacial paralysis.

In a rapid review of high technology in medicine, it is only possible to select specific spin-offs of the space program given the large number of collaborating institutions and the constantly changing state of the art in research, development and application. Information about aerospace exploration and medical applications will be obtained by the laboratory aboard the space shuttle, and by the orbiting observatory. The observatory will contain an advanced-imaging

telescope weighing 12.5 tons which contains a mirror that is at least 50 times more sensitive than research telescopes that are available on earth for accessing the stars. The space station that is presently being designed and planned for deployment in the 1990's would allow experiments under relatively gravitation-free conditions to be conducted in pharmaceutical manufacturing, ultra pure semiconductor crystal development, and life sciences exploration.

It is hard to imagine a more exciting journey than the trek of the Pioneer 10 satellite launched over 12 years ago. This satellite has recently left our solar system and has traveled over 4.7 billion miles. It has already sent back over 125 billion bits of information which is still being processed. It carries with it a gold plaque containing a symbolic representation of man's and woman's perception of the atom and the solar system. By the year 2000, Pioneer 10 may meet up with a mysterious object which seems to exercise inordinate gravitational pull on the outer portion of our solar system. This object is a dark star, a tenth planet, or some as yet unseen but perhaps not unimaginable presence awaiting our investigation. The potential medical impact of the information we may obtain from satellite probes that have recently exited our solar system is still yet to be realized. **OSMA**

Kim Goldenberg, MD, FACP, formerly Senior Test Operations Engineer in the Grumman/N.A.S.A.-Lunar Lander Program, is now Director of the General Internal Medicine Division at the Wright State University School of Medicine, Department of Medicine in Dayton, Ohio.

OBITUARIES

JULIJONAS ABRAITIS, MD, Cleveland; First Moscow Order of Lenin Medical Institute, Moscow, USSR, 1917; age 97; died February 4, 1988; member OSMA and AMA.

NICHOLAS G. AMATO, MD, Cincinnati; Rush Medical College, Chicago, IL, 1938; age 79; died February 28, 1988; member OSMA and AMA.

KURT C. BECKER, MD, Novelty; Ohio State University College of Medicine, 1915; age 96; died February 22, 1988; member OSMA and AMA.

HOWARD M. BOOCKS, MD, Chiefland, FL; University of Cincinnati College of Medicine, 1921; age 92; died January 13, 1988; member OSMA and AMA.

HELEN S. BROGDEN, MD, Canton; Ohio State University College of Medicine, 1928; age 83; died January 23, 1988; member OSMA and AMA.

GAIL W. BUSCH, JR., MD, New Carlisle; Medical College of Virginia Commonwealth University School of Medicine, Richmond, VA, 1954; age 63; died January 21, 1988; member OSMA.

JOHN L. CALLINAN, MD, Cleveland; St. Louis University School of Medicine, St. Louis, MO, 1962; age 51; died February 12, 1988; member OSMA.

DAVID CAUL, MD, Athens; Tulane University School of Medicine, New Orleans, LA, 1949; age 66; died March 14, 1988; member OSMA.

R. FRANK DONLEY, MD, Columbus; University of Cincinnati College of Medicine, 1935; age 77; died February 3, 1988; member OSMA and AMA.

WILLIAM FROSCHAUER, SR., MD, Cincinnati; University of Cincinnati College of Medicine, 1936; age 79; died February 8, 1988; member OSMA and AMA.

PAUL E. GEIGER, MD, Toledo; Loyola University Stritch School of Medicine, Maywood, IL, 1946; age 65; died January 5, 1988; member OSMA and AMA.

KENNETH G. HAWVER, MD, Gainesville, FL; Ohio State University College of Medicine, 1930; age 83; died January 6, 1988; member OSMA and AMA.

JOHN E. HENDRICKS, MD, Newark; Ohio State University College of Medicine, 1934; age 77; died January 27, 1988; member OSMA and AMA.

FRANKLIN HUGENBERGER, MD, Columbus; Harvard Medical School, Boston, MA, 1930; age 83; died February 20, 1988; member OSMA and AMA.

WILLIAM H. HYDE, MD, Laguna Hill, CA; University of Cincinnati College of Medicine, 1924; age 89; died January 15, 1988; member OSMA and AMA.

WILLIAM E. KISHMAN, MD, Lorain; New York Medical College, New York, NY, 1947; age 65; died February 7, 1988; member OSMA and AMA.

LOUIS C. LOEBER, MD, Dayton; University of Cincinnati College of Medicine, 1935; age 79; died January 21, 1988; member OSMA and AMA.

DOUGLAS J. MOORE, MD, Cleveland; Harvard Medical School, Boston, MA, 1946; age 65; died January 21, 1988; member OSMA and AMA.

PAUL MUTSCHMANN, MD, Albuquerque, NM; University of Iowa College of Medicine, Iowa City, IA, 1922; age 91; died January 9, 1988; member OSMA and AMA.

ALBERT I. REAVEN, MD, Akron; Rush Medical College, Chicago, IL, 1937; age 77; died February 13, 1988; member OSMA and AMA.

MAURICE D. SACHS, MD, Carmel Highland, CA; Medizinische Fakultät der Universität Bern, Bern, Germany, 1935; age 78; died December 17, 1987; member OSMA and AMA.

GEORGE L. SACKETT, SR., MD, Stuart, FL; Tulane University School of Medicine, New Orleans, LA, 1929; age 86; died March 3, 1988; member OSMA and AMA.

HAROLD S. SCHIRO, MD, Cincinnati; Johns Hopkins University School of Medicine, 1933; age 79; died February 6, 1988; member OSMA and AMA.

EDWARD D. SCHUITMAN, MD, Genoa; University of Cincinnati College of Medicine, 1921; age 93; died March 7, 1988; member OSMA and AMA.

RALPH C. SCHWARZ, MD, Cincinnati; St. Louis University School of Medicine, St. Louis, MO, 1955; age 57; died January 7, 1988; member OSMA.

BRUCE SIEGEL, MD, Columbus; Ohio State University College of Medicine, 1969; age 44; died January 25, 1988; member OSMA and AMA.

ROBERT G. SMITH, MD, Sun City, AZ; Ohio State University College of Medicine, 1931; age 81; died January 23, 1988; member OSMA and AMA.

CONTINUING MEDICAL EDUCATION

Refresher Seminar in Pediatrics: The Child with Seizures

When: May 18, 1988

Where: Bunts Auditorium
Cleveland Clinic
9500 Euclid Avenue
Cleveland, OH 44106

Credit: 5 hours, Category I

Fee: \$90, physicians; \$70 residents and nurses

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Contact: The above at 9500 Euclid Avenue
Cleveland OH 44106
1-800-762-3172 (Ohio)
1-800-762-3173 (outside Ohio)

Pediatric Epileptology

When: May 19-21, 1988

Where: Bunts Auditorium
Cleveland Clinic
9500 Euclid Avenue
Cleveland, OH 44106

Credit: 18 hours, Category I

Fee: \$250

Sponsor: Department of Continuing Education

The Cleveland Clinic
Education Foundation
Contact: The above at 9500 Euclid Avenue
Cleveland, OH 44106
1-800-762-3172 (Ohio)
1-800-762-3173 (outside Ohio)

Diagnosis and Treatment of Headaches in Adults and Children

When: May 25, 1988

Where: Bunts Auditorium
Cleveland Clinic
9500 Euclid Avenue
Cleveland OH 44106

Credit: 7 hours, Category I

Fee: \$100, physicians; \$75, residents, nurses, allied health

Sponsor: Department of Continuing Education
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Contact: The above at 9500 Euclid Avenue
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New Members . . . continued

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Walter J. Drugan, Jr., MD,
Ravenna

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Fremont

Wade E. Young, MD, Fremont

SUMMIT (Akron unless noted)

Michael J. Evans, MD

Robert W. Faulkner, MD

Phil Fontanarosa, MD

Richard N. O'Desky, MD

S.S. Polsky, MD

Patrick Riley, MD

Hugh A. Schuckman, MD

TRUMBULL

Thomas D. Kaminski, MD,
Canfield

WASHINGTON

Mary E. Gerst, MD, Marietta



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R. Macknin Insurance Agency, Inc.
3681 Green Road
Beachwood, Ohio 44122
(216) 464-4080

BOWLING GREEN

Bartlett Insurance Agency
121 East Court
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CINCINNATI

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FMS Insurance Agency
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Hoffman, Ries & Associates
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Rudd Insurance Agency, Inc.
239 West Court Street
Cincinnati, Ohio 45202
(513) 721-7766

Thomas E. Wood, Inc.
1500 Carew Tower
Cincinnati, Ohio 45202
(513) 852-6339

CLEVELAND

Haas Insurance Agency
25000 Center Ridge Road
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COLUMBUS

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COSHOCTON

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Associated Insurance Consultants, Inc.
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605 Spitzer Building
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Ohio's Medicaid Drug Formulary:

(What You Need to Know)

The Medicaid program is a cooperative, federal/state, cost-sharing program, designed to enable participating states to furnish medical assistance to persons whose income and resources are insufficient to meet the costs of necessary medical care and services. The federal government sets out guidelines within which the states must operate their programs in order to receive federal financial participation which amounts to approximately 59% of the program's service costs.

In Ohio, covered services include pharmaceutical products prescribed by physicians. They are readily available if they are listed in the Ohio Medicaid Drug Formulary. This listing contains selected name brand and generic formulations which are available if prescribed by a physician who participates in the Medicaid program. Those legend and over-the-counter products contained in the formulary are regularly reviewed with regard to research findings, price updating and cost-effectiveness, and are revised each calendar quarter as needed. The department has constituted a Pharmacy and Therapeutics Committee to provide advice and

counsel with regard to items to be included in the formulary. That committee is comprised of practicing physicians and pharmacists, as well as representatives from the pharmacology and nursing professions. Their quarterly meetings are open to the public and public comment is encouraged, received and considered in their deliberations.

Any non-formulary drug which a physician believes to be essential for treatment may be available to Medicaid beneficiaries if authorized by the Ohio Department of Human Services in accordance with the following general criteria:

- a. the drug is scheduled for coverage in the formulary in a subsequent update; or
- b. the formulary generic equivalents of a non-formulary drug have not elicited a desirable therapeutic response and such fact has been documented by the physician; or
- c. the formulary generic equivalents of a non-formulary drug have caused an allergic reaction and such fact has been documented by the prescribing physician; or

*By Jerome E. Friedman, JD
Ohio Department
of Human Services*

Either the physician or pharmacist will be required to seek authorization from ODHS to secure coverage and guarantee reimbursement of the non-formulary drug.

- d. there is no formulary drug to treat the medical condition of the patient; or
 - e. the non-formulary drug was provided during a hospital inpatient stay and is necessary for the continuation of therapy.
- Certain categories of drugs are not covered under any circumstances, including:
- a. any drug for obesity; or
 - b. any drug for fertility; or
 - c. any DESI drug (drug identified as ineffective by the Federal Food and Drug Administration) or drug that has an equivalent active ingredient and/or route of administration; or
 - d. any experimental drug; or
 - e. any vaccinations, inoculations or immunizations not specifically addressed in the formulary.

Recently attention has been focused on certain name brand drugs for which the Federal Health Care Finance Administration (HCFA) established upper ceiling reimbursement limits above which they will not share in the states' costs. This effectively replaced many name brand drugs which had been on the formulary with the generic equivalents which have been found by the Food and Drug Administration to be bioequivalent. Although the HCFA guidelines purport to provide the states flexibility in pricing certain drugs above the established ceiling price, any "overpricing" must be matched by a corresponding "underpricing" of another designated drug, so that in the aggregate the ceiling prices are not exceeded.

The untenability and complexity of this over and underpricing scenario as well as time constraints involved in the administrative rule filing process led the department to adopt, effective October 29, 1987, all the federally established price ceilings, except in those cases where Ohio has previously adopted a maximum allowable cost (MAC) for multi-source available drugs. An allowance was made for the physician to override the formulary limitations and to seek authorization for one of the excluded name brand drugs if she/he documents that the particular patient's condition meets one of the existing exception criteria for authorization of non-formulary drugs set forth above.

In practice, this means that either the physician or more likely the pharmacist will be required to seek authorization from ODHS in order to secure coverage for and guarantee reimbursement of the non-formulary drug. In an emergency situation, the drug may be dispensed and authorization sought after the fact. The key issue is that the physician must effectively communicate to the pharmacist that the patient must receive the prescribed name brand drug (i.e., Dispense as Written — D.A.W.), and she/he must provide the pharmacist with the underlying basis upon which she/he has concluded that the name brand is necessary. If that basis meets one of the identified criteria, then the drug likely will be authorized.

At a public hearing held on December 8, 1987, ODHS heard testimony regarding the proposed permanent rules to implement the

aggregate ceiling limits. Specific concerns were raised regarding special populations' needs, and in particular, persuasive clinical testimony was presented regarding the therapeutic class of anticonvulsant drugs. Four such drugs were impacted by the HCFA directive: Tegretol, Mysoline, Dilantin and Depakene.

The Pharmacy and Therapeutics Committee recommended that the reinstatement of this therapeutic class be considered as their highest priority. In addition, the department received significant correspondence from practicing physicians, pharmacists and members of the public which focused on this therapeutic class of drugs and the unique situation of persons subject to seizures as a result of epilepsy.

The Ohio Department of Human Services, after due consideration of all of the implications, has decided to amend the proposed rule and to reinstate in Ohio's Medicaid Drug Formulary effective January 27, 1988, the class of name brand anticonvulsant drugs that were adversely affected by the "upper ceiling limit" regulations.

While the department appreciates the efforts of the Pharmacy and Therapeutics Committee in its prioritization of the issues at hand, at this time, we have elected not to pursue their additional recommendations about the other name brand drugs for which upper-ceiling reimbursements were established by the HCFA. Rather, the department intends to closely

continued on page 405



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Slow-K®
potassium chloride
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For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control mild cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSEAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSEAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSEAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSEAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

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Consumer Pack—One Unit	
12 Bottles—100 tablets each	NDC 0083-0165-65
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Do not store above 86°F (30°C). Protect from moisture. Protect from light.

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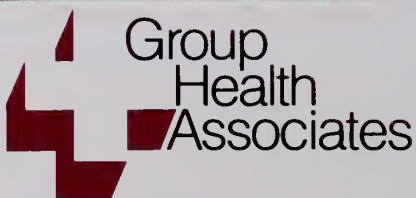
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Drug Formulary . . . continued

monitor prior authorization requests for all drugs affected by the recent federal regulations. To date, the few objections which have been raised concerning the cardiovascular and for that matter, other drugs removed from the formulary to comply with federal regulations, have not effectively made a case for the lack of viable alternatives.

The department's decision to place the name brand anticonvulsants back on the formulary is an example that proves the department's dedication to providing a managed, comprehensive, cost-effective drug formulary in compliance with federal regulations, while not compromising the health care of Ohio Medicaid beneficiaries in the process. **OSMA**

Jerome E. Friedman, JD, is Chief, Medicaid Policy Bureau at the Ohio Department of Human Services.

Comment from Janet K. Bixel, MD, OSMA representative on the Medicaid Pharmacy and Therapeutic Committee: Until HCFA started telling the states how to manage their formularies, we in Ohio had a comprehensive cost-effective Medicaid formulary, developed with input from many OSMA members. If you are having problems with HCFA's decisions, please write William L. Roper, MD, Administrator, HCFA, 200 Independence Ave., S.W., Room 314-G, HHH Building, Washington, DC 20201, and send me a copy at 289 E. State St., Suite 200, Columbus, Ohio 43215.

AMA Impressions

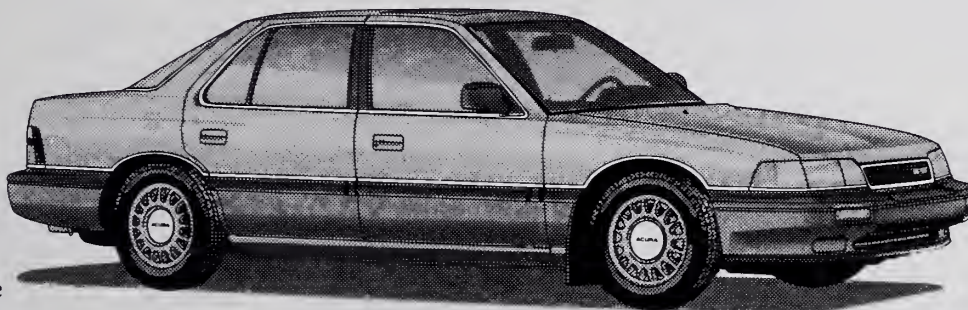
. . . continued

we need to be flexible to survive." He felt that the conference emphasized AIDS as a major concern of this time and that it can be approached in a sensible way. He said, "AIDS is a fatal but not a highly infective disease." Dr. Clarke also sees developing a support system for AIDS victims as a high priority for our society.

AMA National Leadership Conference 1988, "Strategies for Success": Certainly this was a conference full of national physician leaders, certainly many strategies were presented and certainly there is hope for success in the future. Meeting like this and tying our present leadership to the roots of our past and the seeds of our future provides hope for the tomorrow of organized medicine. **OSMA**

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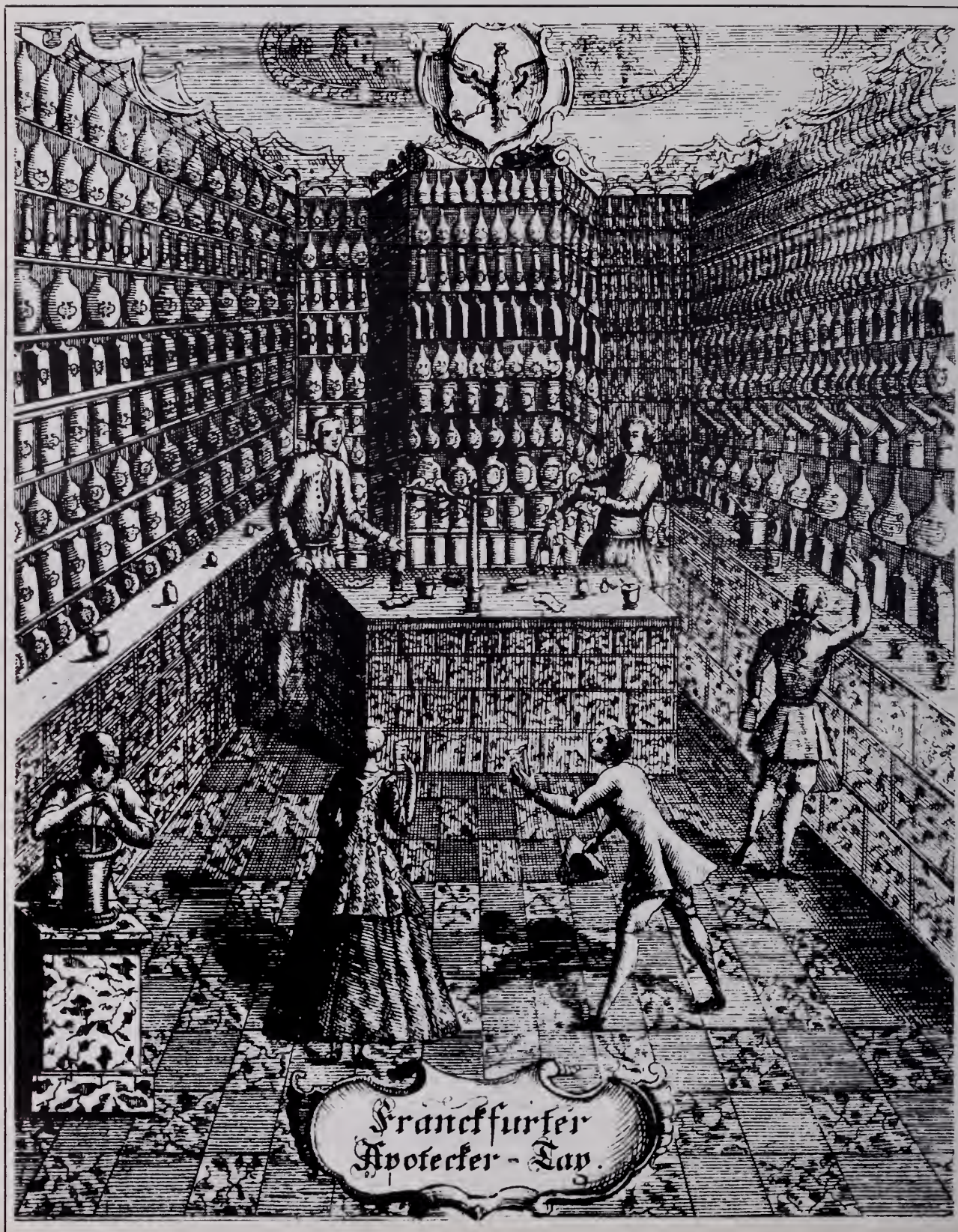
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Editor's Note: *John C. Steiner, MD, submitted his observations to help other physicians in the recognition of drug-seeking behavior.*

Scenario for Drug-Seeking Behavior in a Solo Consultant's Office

By John C. Steiner, MD

How appointment is made:

Physician request:

- Physician personally calls me requesting help with a patient to be seen quickly.
- Physician is often uneasy about the amount of narcotics he has prescribed or that the patient is seeking. Sometimes the patient is new to him; sometimes there are chronic problems with problems in dealing with another illness. Diabetes out of control, ulcers, etc.

Spontaneous patient request:

- Reported referral from phone referral service (almost never from Yellow Pages).
- Call in the morning after Emergency Room the night before.
- When patient/physician says this is an emergency, person told to come to the office. No other contact with the office. "Send him over, or come on over."
- Person seldom lists insurance plan on registration sheet. Incomplete data. Often doesn't sign.

Patient reports that headache/pain is of present increasing severity:

- external pain manifestations increase as the encounter continues.
- pain is constant and increasing — present 100% of the time.
- history of pain location, duration, is often diffusely described.
- history of lifelong migraine headaches but specific details not recalled, or responds with "yes" or "no" to multiple choice questions I ask.
- patient seldom familiar with prophylactic migraine treatment; if tried often adverse reaction.
- patient often notes Percodan, Vicodan, Dilaudid, Demerol, etc., don't work but sedate. Often reports reactions to many other types of non-narcotic medications.
- patient knows the drugs we use, often with medically-related experience — seldom disclosed.
- patient often requests stronger pain medications which can be given right now.

— often specifically avoids mentioning the word "narcotics," but wants something STRONG.

— patient reports something increases pain, but if it is done, there is inconsistent response.

— often other addictive behavior found — smoking 2+ packs of cigarettes daily.

— lethargic effect; later, when pressured, gives an enormously verbal account of what transpired.

Strategy for management of migraine/pain explained:

— I tell the person that narcotics don't work for migraines, but I can help reduce pain in time.

— I explain strategy for migraine/pain control — nausea, gut irritation control.

— I explain acute and chronic pain control — endorphins, analgesic, withdrawal, headache, etc.

— side effects of medication explained as much as possible. Drug information sheet often given.

— prescriptions for non-narcotic

medication given, usually two or three.

— Pain Center referral, if suggested, often poorly received.

Followup:

— patient is asked to call the following day to tell me how things are going.

Fee:

— I take the patient's chart to the front desk, give further instructions and return to my office.

— Office staff then always reports that derogatory comments are made. Voice often loud.
(1) "He didn't give me anything."
(2) "He ripped me off."
(3) "What does he care about my pain?" (4) "He didn't examine me well." (5) "Too much money!"
(6) "You never told me!"

— Nonpayment at time of service: Forgot checkbook . . . credit card off limits . . . bill my insurance . . . never leaves a post-dated check.

Call returned:

— 60% don't return call
— If a call, generally afternoon. Medications not working. Side effects! Vomiting most often.

— When I return call: Always aggressive: (1) "Why did you give me an antidepressant for pain? I'm not depressed." (2) "What's the idea of giving me an 'anti-inflammatory' drug?" (3) "Your drug made me sick." (Migraine is associated with nausea.) (4) "Why did you give me a stomach pill? (Reglan) (5) "What are you going to do now?"

— Often confrontation: "Why didn't you give me _____?"
"You think I'm a druggie, doper, user, addict, don't you?"

— I usually agree if it's gotten this far, but tell them that I am willing to help them with their pain. There are often:
(1) vituperative comments
(2) critical and threatening

behavior (3) phone receiver often slammed down (4) occasional angry letter follow-up with further threats (5) nonpayment of the bill — always.

A call to the referring physician generally reveals that he suspected drug-seeking behavior. There is sadness on both our parts, because the patient has a problem and has not been helped. He apologizes for sending the difficult patient, and I tell him that this is what I sometimes see and accept as part of the practice, because I have difficult patients, too, and will need his help. I wish I had a better solution for this problem, however.

John C. Steiner, MD, practices neurology in Cincinnati.

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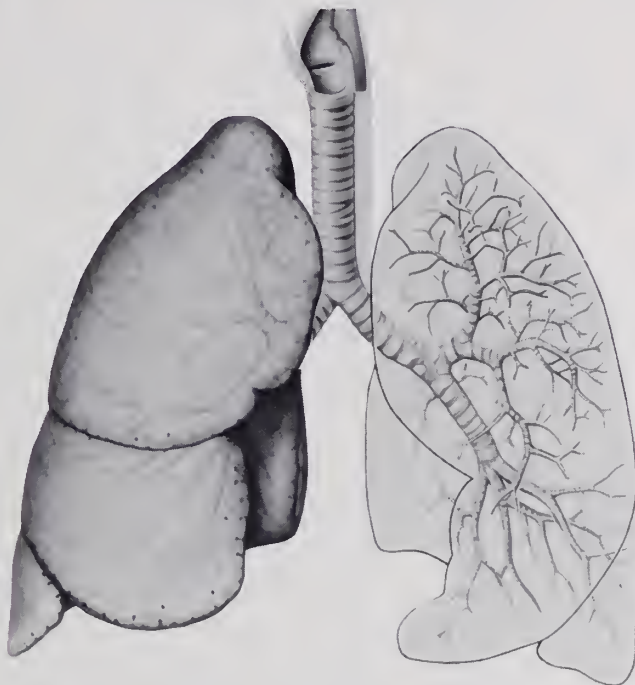
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Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Summary. Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:

CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

- Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2-5%

- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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The Psychologically Battered Child

*James Garbarino, Edna Guttman and Janis W. Seeley;
Jossey-Bass Publishers, San Francisco, 1986; 286 pages*

Protection from psychological maltreatment as a basic right of all developing children is the goal of the book entitled "The Psychologically Battered Child," written by three social scientists. James Garbarino, senior author and an international expert in child development, won the first National Conference on Child Abuse and Neglect's C. Henry Kempe Award for outstanding work in the field of preventing and treating maltreatment of children.

Most physicians agree that the absence of physical assault does not reduce the seriousness of sexual abuse since the main threat to a developing child is loss of emotional stability. The authors likewise propose that in domestic and community violence, the main danger is chronic emotional abuse and the resulting permanent psychic damage.

The book stresses the importance of parents encouraging a child's normal developmental progress by providing unrequited love and acceptance. Each child has a right to:

1. A responsive parent who recognizes and responds positively to socially desirable accomplishments.

2. A parent who doesn't inflict on a child the parent's own needs at the expense of the child's.

A positive interactive childhood results in children with a sense of identity and integrity. It also

prevents a cyclic continuation of disturbed parenting which continues the risk of child abuse in future generations.

The authors build their case in Chapter 1 by defining the term "emotional abuse" as a result of deliberate parental action which has caused significant emotional disturbance in a child — the frequency of which is estimated to be at least one in 500 children per year. Absence of psychological maltreatment is the key to emotional stress resistance which allows the development of a self concept and social competence.

In the next chapter, five forms of emotional abuse are illustrated in 20 case studies of psychological battering. The parental behaviors, resulting in psychological maltreatment, include: rejecting, terrorizing, ignoring, isolating and corrupting a child. The authors vividly demonstrate that in each major stage of a child's life through adolescence, emotional abuse can be devastating to a developing social being.

The third chapter delineates practical strategies for identifying cases of emotional abuse.

Developmental consequences of maltreatment include disturbed patterns of behavior, such as withdrawal or aggressive hostility. Chapter 4 discusses assessment of the causes and effects of psychological battering with the use of standardized psychological instruments.

In the fifth chapter, intervention to alter family dynamics and creating and maintaining an environment of emotional abuse are discussed. Over 3,000 different child protective service systems in this country are available to intervene. However, the authors' strong plea for action breaks down as these agencies are known to be fragmented, of poor reputation and severely under-funded. Their case for identification and assessment of emotional abuse would be better accepted if the intervention process for physical and sexual battering was effectively established at this time.

The sixth chapter addresses the special needs of particular families and their members. Chapter 7 reveals how to mobilize community resources to intervene at the local, state and federal level. The principal author, who has done many of the original studies in this area, develops his idea through the use of "community development" and "social planning" approaches integrated in a systems model process.

In the final two chapters, psychological battering in out-of-home care for children is discussed. Using five case examples, the authors illustrate the fact that services designed to help children are often the site for abusing them — the frequency of which may exceed four per 100 institutionalized children as

reported by a study in 1984.¹

Being well-referenced, the text is followed by 24 pages of current interdisciplinary studies on assessing and treating child abuse. In addition, there is an appendix outlining the sources of personality assessment techniques helpful in determining probability of psychological battering.

The authors are to be commended for demonstrating that abuse and neglect of children are indicators of underlying problems in family, community and governmental priorities. They cover the subject very completely, but too superficially to be of significance and help to the busy primary care physician. One leaves

the initial reading with more questions than answers.

By calling for a more mature response to the problem of child abuse and neglect, however, the authors will stimulate research into documenting the consequences of emotional abuse. Hopefully, it will also stimulate a closer working relationship of professionals in child welfare and mental health problems.

With this in mind, I would strongly recommend this book to professionals in child welfare, public and mental health programs, psychiatrists and juvenile court judges, as well as socially concerned primary care physicians. If the social needs of

our children are addressed as Hoekelman believes,² the second edition of this book may be required reading for all physicians in the future.

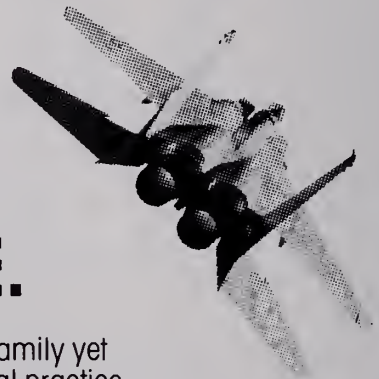
— **Joseph A. Abram, MD,**
FAAP, Youngstown

REFERENCES

1. Rindfleisch, N. et Rabb, J. "How Much of a Problem is Resident Mistreatment in Child Welfare Institutions?" *Child Abuse and Neglect*, 1984; 8, 33-40.
2. Hoekelman, R.A. et al. *Primary Pediatric Care* C.V. Mosby Co., 1987 pg. 2.

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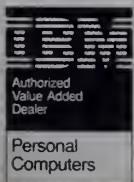
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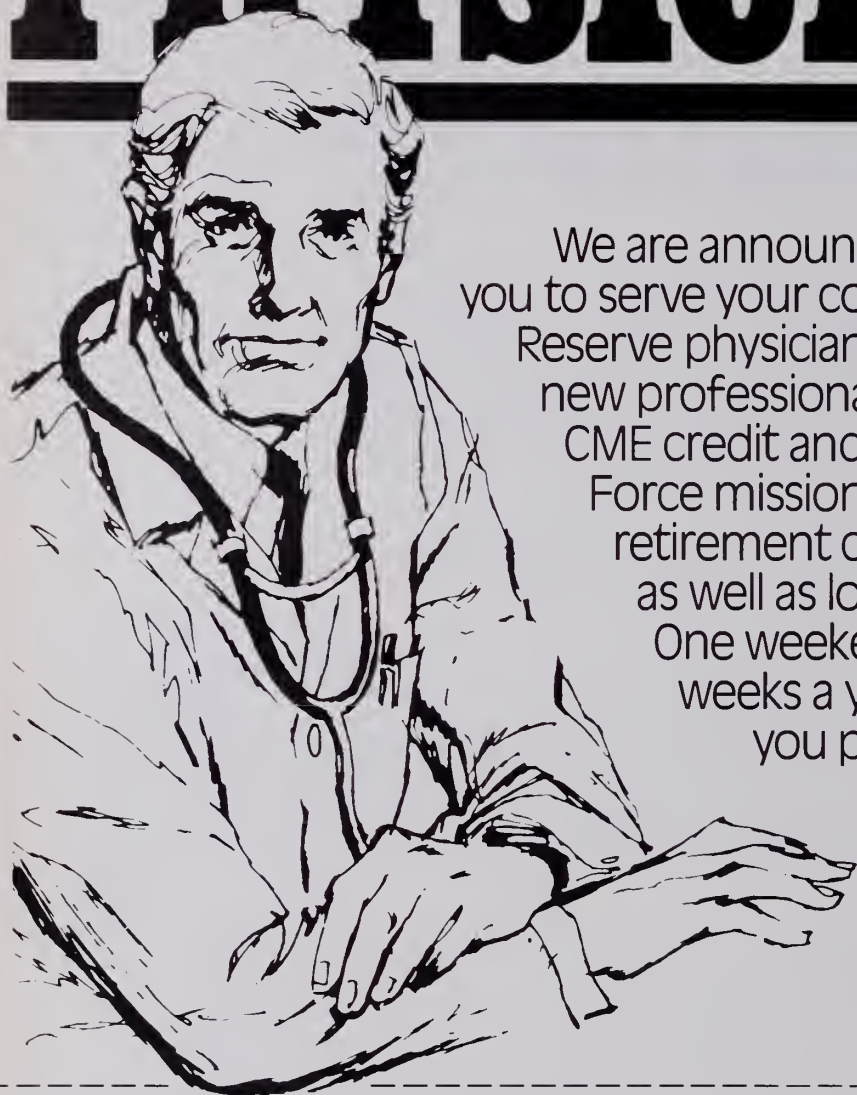


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The Good News About Depression. Cures and treatments in the new age of psychiatry

*Mark S. Gold, MD; Villard Books, 1987; 328 pages;
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After “patiently and steadfastly” educating his colleagues “in hundreds of professional publications, in symposia and lectures,” Dr. Gold, author of *“The 800-Cocaine Book,”* turns to the lay reader to “reduce the lag time” in the implementation of new scientific ideas, specifically “biopsychiatry.” In his words, “Biopsychiatry has appeared on its white charger . . . to rescue the profession and its patients.” He warns that “if biopsychiatry theory and practice . . . are not immediately adopted by every psychiatric practitioner, the profession will collapse.”

Throughout the book, the presentation of information is scattered. It seems as if Dr. Gold wants to communicate his ideas on insurance, the medical school and residency training process, other mental health practitioners, other physicians and other psychiatrists. For some reason, he feels a chart of doctors’ earnings relative to specialty is relevant, and includes that early in the text. There is considerable we-they thinking. Subheadings such as “Everybody’s Doing Something Wrong” will detract from its charm for many medical readers.

There is some good information about certain new developments in psychiatry, and informative and thought-provoking points are made. Specific attention is paid to

the limitations of the DSMIII. There is a review of the relationship between various physical illnesses and depression. Dr. Gold’s emphasis is constantly to destigmatize the illness. The lay reader would learn a good deal about depression and the complexity of factors — somatic, genetic, neurochemical and environmental — associated with depression. There is also an overview of various types of

a statement such as, “The alert physician can fingerprint a person’s mood on the basis of his or her calcium level.” Occasionally, medical terms such as “antigen” and “tardive dyskinesia” are presented without explanation.

There are also confusing contradictions, including a subchapter on women’s special risks, which ends with a paragraph suggesting the equality of risk of

The lay reader would learn a great deal about depression. However, some of the medical information provided might cause the medical reader to take pause.

affective disorders, which readers should also find enlightening.

However, some of the medical information provided might cause the medical reader to pause. Is it really true that “Most people with MS end up in wheelchairs”? What is the likelihood of a pancreatic tumor causing depressive symptoms for 10 years prior to detection?

Some oversimplifications are troubling, such as “Learning Disabilities = Depression/Depression = Learning Disabilities.” The lay reader might also expect too much upon reading

both sexes. I thought he’d done a good job of pointing out neurohormonal contributions, but wondered why he took a stand and then seemed to undermine it.

Although the book provides useful information on depression for the lay reader, the author unfortunately falls prey to the very contentiousness which he decries. This attitude does not lend itself to a broad medical audience, but it is not a medical audience for whom the book is written.
— Diane M. Vickery, MD,
Cincinnati

FACTOR XI DEFICIENCY IN A GERIATRIC POPULATION

William D. Loeser, MD, FACP

Emil S. Dickstein, MD, FACP

An elderly Ashkenazic Jewish population was studied for the presence of Factor XI deficiency. Four kindreds in this geriatric group were discovered, the highest density of the abnormality ever reported, and the first for a specific geriatric group in a small community setting. Ten members of the four kindreds were identified, four of whom had total or near-total Factor XI deficit, the other six having from 25 percent to 65 percent of normal activity. Factor XI deficiency may be far more common in selected elderly populations than previously thought.

Introduction

Factor XI deficiency is a seemingly unimportant genetic abnormality of the clotting system. This rare defect occurs predominantly (but not exclusively) in Ashkenazic Jews.¹ The first determination of a deficit of Factor XI, also known as Plasma Thromboplastin Antecedent or PTA, was made in 1953 by Rosenthal, hence the eponymic "Rosenthal's Syndrome."² In due time several hundred cases have been reported, mainly in the New York area.³ A kindred study recently published a dichotomy in patients with the abnormality, one group of families having a tendency to bleed and the other group with no bleeding tendencies. The reason for this is unknown.⁴

William D. Loeser, MD, FACP, is medical director of Heritage Manor, the Jewish Home for the Aged, in Youngstown; Emil S. Dickstein, MD, FACP, is associate medical director of the same facility.

The original consideration of this condition as a rarity was dispelled somewhat by the recently published report by Muir and Ratnoff documenting seven patients in Cuyahoga County, Ohio, all of Jewish origin.¹ Their demographics resulted in an estimated carrier state in their population of 1/56 and the state of total or near-total deficiency in their Jewish population of on the order of 1/12,000. These estimates were produced without consideration of the age of their affected groups.¹

The discovery of a case of total Factor XI deficiency in an 84-year-old gentleman at the Jewish Home for the Aged where we are medical directors led us to investigate its local incidence in the elderly Jewish population of Youngstown, Ohio. All members of the nursing home facility were checked, as were family members and various older Jewish residents of the community.

Materials and Methods

Partial thromboplastin times were obtained in all 64 Jewish nursing home residents (ages 68 to 98), the six available family members of affected residents, of whom four were over age 65, and 12 unrelated elderly members of the general Jewish community of Youngstown, Ohio. Factor XI levels were determined in all people with abnormally elevated results. The standard testing methods for partial thromboplastin time and Factor XI level were employed.⁴

Two case reports will illustrate appropriate points we wish to make with regards to discovery of the abnormality and its relative significance.

An 84-year-old man hospitalized for surgery was found to have a preoperative partial thromboplastin time of over 100 seconds. Factor XI level was zero percent. Fresh frozen plasma was transfused and an uneventful decubitus ulcer excision was performed. The patient's identical twin brother was likewise found to have a Factor XI level of zero percent. Neither gentleman has any bleeding tendencies.

An 84-year-old woman had surgery for breast cancer post-

poned when her preoperative partial thromboplastin time was found to be in the 100-second range. Factor XI level was zero percent. A mastectomy was performed after fresh frozen plasma was given and the PTT normalized. Unfortunately the patient sustained a massive myocardial infarction one week later and died. This patient did have a history of bleeding tendencies, and was a resident of the nursing home because her joints, particularly her knees, had deteriorated such that she could no longer walk, a phenomenon known as atypical hemophilia in Factor XI deficiency.⁴

Results

Five residents of the nursing home had clearcut Factor XI deficiencies. Additional elderly family members with the deficiency were found, as was an unrelated older member of the general Jewish population.

The Factor XI levels obtained fell into two groups: O, O, O and 1 percent of normal activity; and 25, 35, 49, 59, 61 and 65 percent of normal activity.

Some were clinical bleeders, some were not. All were Ashkenazic Jews.

Family 1: Three brothers and a sister, all over age 66, Factor XI levels of 1 percent (a known bleeder), 25, 61 and 65 percent. Their deceased mother was a known bleeder.

Family 2: 84-year-old identical twin men with Factor XI levels of zero percent. No known bleeding tendencies.

Family 3: 96-year-old man with 49 percent of normal Factor XI activity and history of major bleeding during minor surgery requiring nine pints of blood.

Family 4: 84-year-old woman alluded to in case history with zero percent Factor XI activity, hemophilic joints, and fatal myocardial infarction after correction of PTT abnormality.

Others with 35 and 59 percent activity, non-bleeders.

Discussion

Youngstown, Ohio has a Jewish population of 5,000, of

which one quarter is above the age of 65 years. Four members of this group of 1,250 geriatric patients have been identified by us as having total or near-total Factor XI deficiency, for a minimal incidence of 1/300 and a minimal carrier rate of 1/9, six times as common as that hypothesized by Muir and Ratnoff.⁴ If this is not an isolated phenomenon in Youngstown (for whatever reason), it would make Factor XI deficiency a very common disease of the Ashkenazic Jewish population, unrecognized because of its apparent clinical insignificance, and quite unthought of in the elderly contingent.

It is unknown if the aging process itself results in a gradual loss of Factor XI. There are no analogous situations in the clotting factors or similar enzymatic processors that we are aware of.

It is also unknown if the mild blood-thinning effect of the lack of a relatively unimportant clotting factor could protect against atherogenesis or intravascular clotting and prevent the major morbidity due to myocardial infarctions, cerebrovascular accidents and the like, selecting out elderly populations with higher incidences of clotting factor deficiencies.

Further direction of studies of Factor XI and other deficiencies should be aimed at large, age-controlled cohorts to determine whether or not our findings are reproducible, to determine significant morbidity and mortality statistics, and the degree of atherogenesis in the factor-deficient groups.

REFERENCES

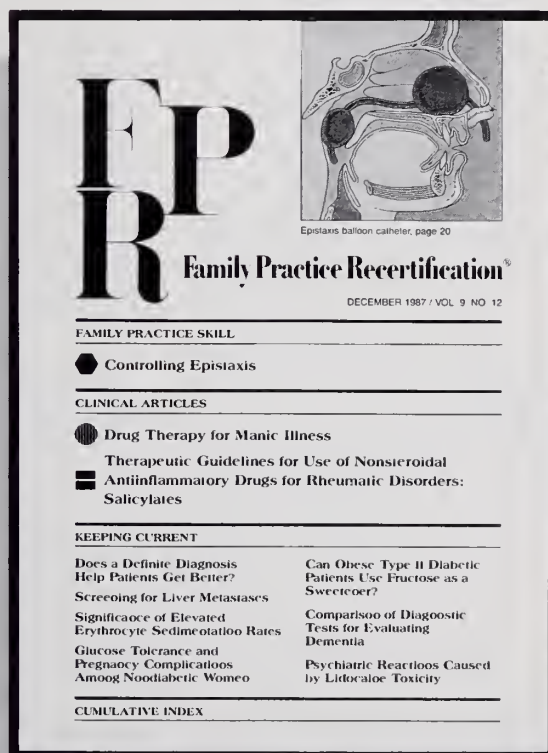
1. Muir, WA, Ratnoff, OD: The prevalence of plasma thromboplastin antecedent (PTA, Factor XI) deficiency. *Blood* 44:569-570, 1974.
2. Rosenthal, RH, Dreskin, OH, Rosenthal, N: New hemophilia-like disease caused by deficiency of a third plasma thromboplastin factor. *Proc. Soc. Experimental Biology* 82:171-174, 1953.
3. Girolami, A, De Marco L, Dal Bo Zanon, R, et al: Rarer quantitative and qualitative abnormalities of coagulation. *Clinics of Hematology* 14:385-411, 1985.
4. Ragni, MV, Sinha, D, Seaman, F, et al: Comparison of bleeding tendency, Factor XI coagulant activity and Factor XI antigen in 25 Factor XI-deficient kindreds. *Blood* 65:719-724, 1985.

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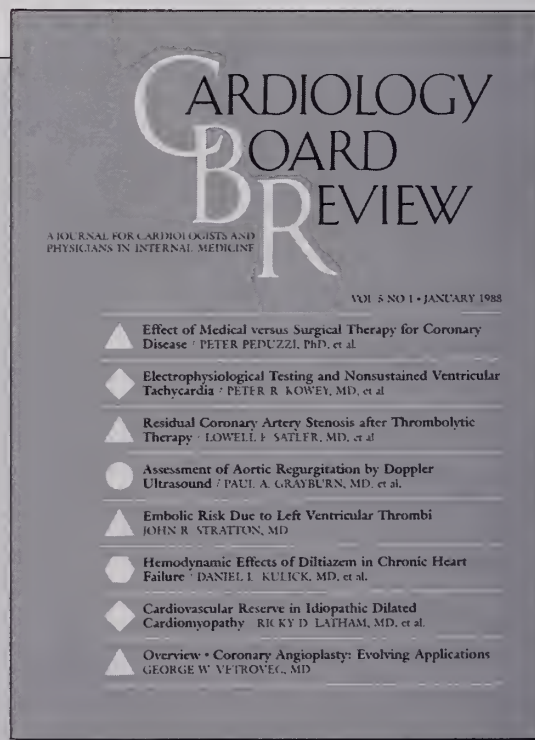
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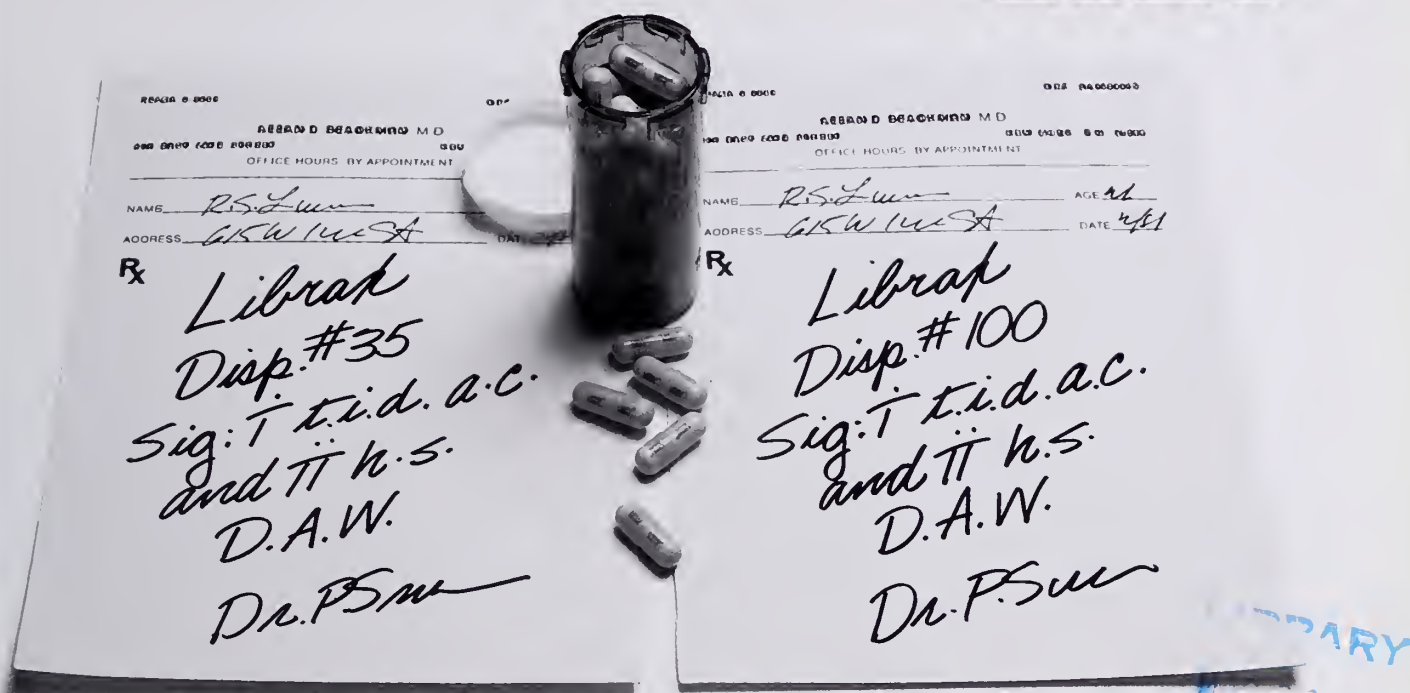
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*Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 84, NO. 6

JUNE, 1988



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New Age
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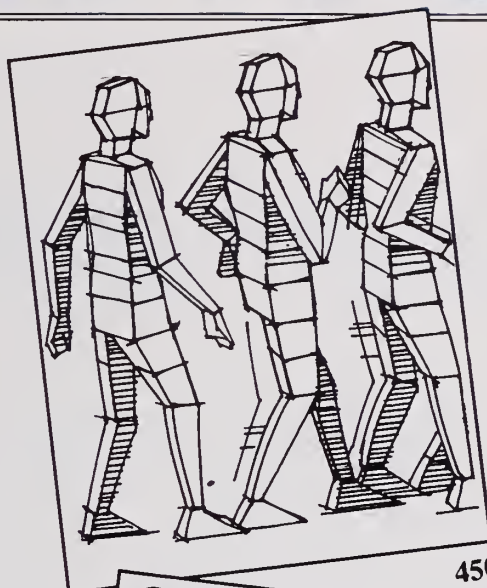
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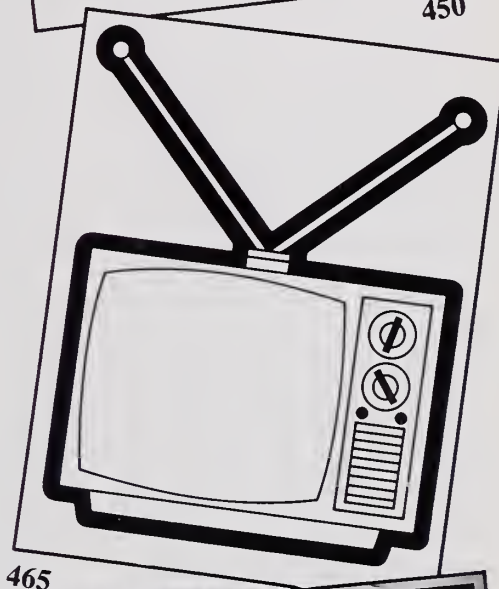
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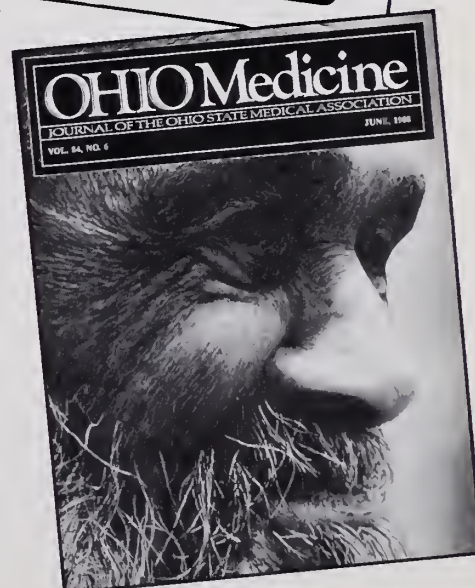
This month's cover was photographed by free-lance artist-photographer Larry Hamill.



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465



The New Technology

Technology has created problems for medicine . . . no question about it. The profession has been thrown into one ethical dilemma after another, thanks largely to the technological advancements that have been made during the past few decades.

Yet, there is also no question about the fact that those same advancements that have placed the profession in complex, moralistic situations have also enabled it to accomplish miracles never before believed possible.

Recently, biotechnicians have begun to turn their attention to what is considered to be one of the most rapidly-advancing areas of medicine — geriatrics. This past spring, the Ohio State University's department of industrial design, along with the division of nursing staff development at University Hospitals held a conference series on "Technology and Aging." We felt it was an important conference to cover for three reasons. First of all, we wanted to make you aware of just how enormous America's aging population will be in the next decade. In her article, Editorial Assistant Michelle Carlson provides you with the demographics of our current — and future — aging population, and exactly what types of problems they will be bringing to you, their physicians. Second, we wanted to place this elderly population into perspective for you. Obviously, you won't be the only profession striving to meet the needs of this population in the future. How will society attempt to meet the elderly's other, non-

medical needs — and what sort of impact will that have on you? Those are the questions Associate Editor Deborah Athy has answered in her article, "The Elderly and Society: The Quest for Independence." Finally, we wanted to show you some of the technological innovations on the horizon which will help to extend and improve the quality of life for older Americans. For that article, however, you'll have to wait until next month.

Also in this issue . . .

You'll notice our "Presidential Perspectives" column has a new face. Donavin A. Baumgartner, Jr., MD, took office as President of the Ohio State Medical Association last month during the association's annual meeting. You'll be reading his own thoughts about medicine throughout the year, of course — but this August, watch for a special profile story that will provide not only a close-up view of the man . . . and physician . . . but also of the goals he has set for himself and the association in the year ahead.

You'll also find several good clinical articles in this issue, as well as some interesting stories in our "Ohio Medi-scene" section.

Next month, we'll once again take a look at the future — this time at some of the issues that will, most likely, be facing society in the 21st century . . . and how those issues might be handled interprofessionally. Don't miss it!

Karen S. Edwards

OHIO Medicine

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Decision Time

By Donavin A. Baumgartner, Jr., MD

When you stop to think about it, there are several similarities between aging and technology. Both have seen rapid development during the second half of the 20th century. Both are escalating at remarkable rates and both the longer life span and advances in technology are viewed by the public as favorable. Ironically, both of these “favorable” trends are major factors in the steady increase in health-care costs, viewed clearly as unfavorable.

Unfortunately, those who have benefited most from the new technology are among the most vocal in decrying the costs. It is understandable that many retirees living on fixed incomes should view with concern any inflation, yet who among them would like to return to the “good old days” of health care when premiums were a fraction of today’s, but forego the advantages brought by technology? Would they like to eliminate ICUs, lens implants, total hip replacements, pacemakers, CT scans and a whole pharmacopeia of new drugs such as the third generation cephalosporins, calcium channel and beta blockers, to

name just the tip of the iceberg? In addition, there are the new technologies of monitoring and telemetry that allow those of advancing age to pursue an essentially independent life far longer than possible in the past.

Not just the length but the quality of life of our population has been improving through technology and yet both are just beginning. It is estimated that our costs of providing long-term care for the elderly will double by 1995. The population will clearly continue to age and technology is on the verge of explosive advances. Once, while discussing the amazing technologic changes we have seen in the recent past, it was noted that my mother has lived from an age of horse and buggy and kerosene lamps to see man walking on the moon. When I ventured the thought that perhaps no generation will ever again see such a span of change in a single lifetime, an engineer corrected me by suggesting that the age of technology is in its infancy and the past will seem tame when compared to the developments in the next 30 years. This is very likely the truth and it is time to face these facts and plan for them.

So both aging and technology have only just begun compared to the future. Do we want to welcome

these changes and provide for the obvious costs? What are the alternatives? There can be no doubt that pretending there is no problem will lead to a variety of measures repugnant to all. We are already headed toward one of these alternatives, that of a two-tiered health system. Much worse, there is the specter of rationing of health care as the government, business and the insurance industry vie to “control” health-care costs. Or are we headed toward a system of age discrimination, now an integral part of the British system? Are those “aged” over 55 to be denied admission to an ICU, prevented from having coronary bypass or prohibited from benefiting by the latest thrombolytic therapy?

These decisions must be faced by the public, not the physicians. These decisions are social and not medical. With no public policy, the physicians of this country will continue to pursue the path they were trained to follow, the best health care for each individual patient. If this is not what the public wants, then they must make it clear. When the question of costs is raised, please be sure that those who answer for the public include themselves and not be allowed to provide, as in the case of federal workers’ health and

retirement plans, an elitist separate system for themselves and another for the "ordinary" citizens. It is very easy to say, "We are spending too much on health care and there must be cuts," yet who as an individual is of that mind set when faced with a need for medical care for a loved one?

Somehow, whenever increasing health-care costs are mentioned it is the physician's fee that seems to be singled out. Never mind the voluntary limits accepted by the profession, never mind the control of fees by Medicare for so many years, and never mind the significant fact that physicians fees account for only 19 percent of the total health dollar. What this means in realistic terms is that if each and every physician worked an entire year completely without any compensation, the total health costs would not even be reduced by 20 percent.

It is not only time that the

necessary decisions on a public policy for health care be made, it is time that all of the concerned factors, including the government, business and the elderly, face up to the fact that physicians must be an essential part of the dialogue and input must be sought from the

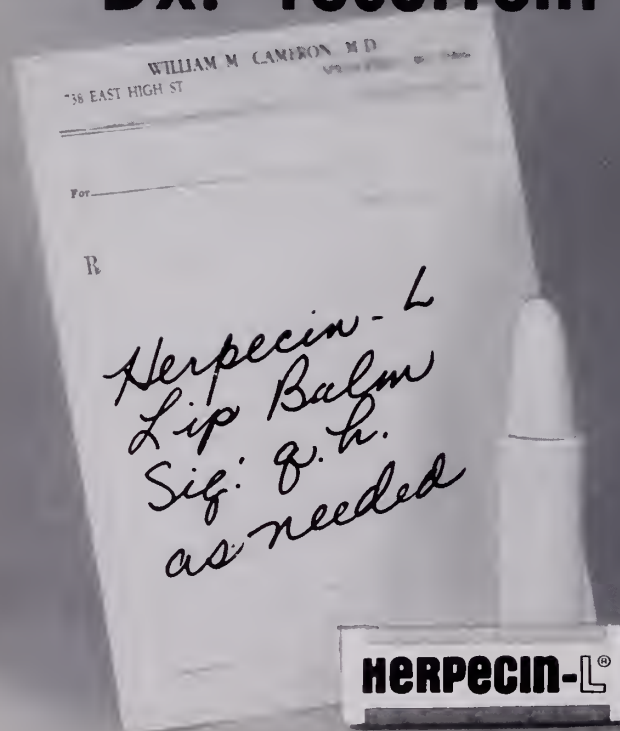
Wanting everything life can provide but not wanting to pay for it has become a national trait.

profession to avoid the costly mistakes of the system when attempts are made to run it without it.

What the public wants is easy to predict — unlimited health care of the very finest but at a cost less

than they are paying today. A poll of Ohio citizens a year or so ago confirmed this. A large percent of those polled indicated that they felt the government had an obligation to provide health care for all, yet they overwhelmingly rejected any increase in taxes to pay for care. The American public is used to such contradictory views. After all, each year politicians run for office promising to vastly expand government programs, eliminate unemployment, balance the budget and lower taxes, raise wages and reduce government size. Wanting everything life can provide but not wanting to pay for it has become a national trait. Yet, we must mature and face the very difficult decisions necessary to provide needed health care. Physicians are ready and willing to do their part. Are the public, the lawmakers, business and labor ready to honestly do theirs? **OSMA**

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Death of a Country and Western Songwriter

A Case Report

Journal authors are often accused of writing in a trite and unimaginative style. Our response is to offer a case history brightened by some vigorous, contemporary language taken directly from popular weekly magazines and AM radio. The readers can judge for themselves what they wish to see printed in journals in coming decades.

A 27-year-old male on a well-deserved winter vacation was observed careening down a dangerous ski slope. His better half called out to him, "You blithering idiot, don't act so high and mighty, don't tempt fate . . . better safe than sorry."

The little woman waited with bated breath as others joined the hue and cry fearing injury to be a foregone conclusion.

"You blithering idiot, don't act so high and mighty, don't tempt fate . . . better safe than sorry."

By Clee Shay, MD

But he called out, "Any danger is a figment of your imagination. These new skis I purchased from the Wroth Brothers, Max and Wax, should allay any fear and trepidation about this slope being fraught with danger," while he tried to dodge a large rock. As he bore down, his life's work flashed before his eyes: ("That Rock Don't Rock and Roll"; "A Country Boy Who Rolled That Rock Away.") Alas he did not react in the nick of time and thus bore the brunt of his folly.

The ski patrol came flying to the rescue, wondering what had raised such a ruckus. These men were present to keep a lid on such incidents. One patrol member, a little down and out but with a heart of gold, ran for the good doctor, duty bound to help those

Death of a Songwriter . . . continued

who court disaster and get laid low.

The good doctor exuded the milk of human kindness but did not mince words. "The die is cast, as you did not walk the straight and narrow. We must shoot the works, as you need an operation beyond a shadow of a doubt."

The patient replied, "There apparently is no last-minute reprieve, so I'll have to face the music. Go ahead Doc, strut your stuff if the time is ripe, before the man upstairs can claim me lock, stock and barrel."

The injured party initially was snatched from the jaws of death and it appeared he would become sound as a dollar. Unfortunately he took a turn for the worse and before they knew it he was dead and gone. **OSMA**

Ref.: People Weekly. Various articles. Vol. 26. No 19. Nov 10, 1986.

WLND. A New Country Station, AM 830. Cortland, Ohio.

Clee Shay, MD, is a pseudonym for William D. Loeser, MD, and Emil S. Dickstein, MD, both members of the Department of Medicine, Western Reserve Care System, Youngstown, and associate professors of medicine at the Northeastern Ohio Universities College of Medicine, Rootstown.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of OHIO Medicine or the Ohio State Medical Association.

Correction

Last month, the article "CT as an Initial Screening Tool: A Step Back Into the Dark Ages?" by W.E. Feeman, Jr., MD, ran incorrectly. The cholesterol retention fraction was defined using a denominator of HDL. The denominator should have been LDL. **OHIO Medicine** regrets the error and any confusion that may have been caused.

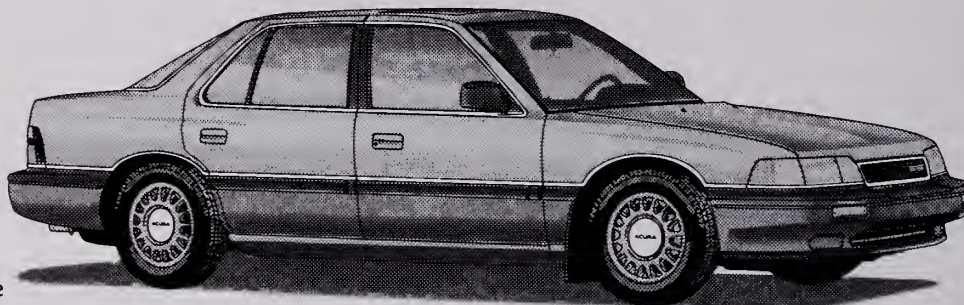
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Everyone has a pet peeve, a gripe, an opinion . . . and we'd like to hear about yours! Second Opinion is in need of material, so now is the time to write us, expressing *your* opinion about whatever subject you wish to address.

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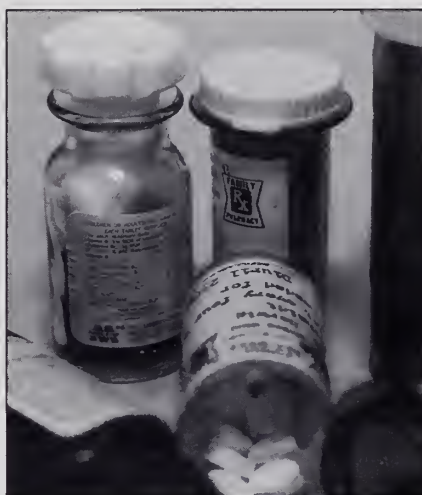
Antibiotics may prevent PCP infections

Pneumocystis carinii pneumonia (PCP), an opportunistic infection that frequently attacks AIDS patients, may be prevented by administering the antibiotics sulfamethoxazole and trimethoprim, according to a report published in a recent issue of the *Journal of the American Medical Association*.

The study, conducted by Margaret A. Fischl, MD, and colleagues at the University of Miami School of Medicine, involved 60 patients with recently-diagnosed cases of Kaposi's sarcoma, a rare skin cancer that frequently afflicts AIDS patients. None of the patients in the study had active or previous opportunistic infections.

While half of the subjects received treatment of sulfamethoxazole and trimethoprim — two drugs commonly used to combat bacterial and protozoan infections — the other half served as a control group. According to the report, no patient receiving drug therapy developed *P. carinii*, while 16 of the 30 untreated patients developed the disease during the course of the study. The authors also note that five treated patients were forced to discontinue drug therapy after experiencing adverse reactions, and that of those five, four developed *P. carinii* within four to five months after discontinuing therapy.

"Toxic reactions to



sulfamethoxazole and trimethoprim were observed in half the patients in the treatment group," the authors note. "In many instances, adverse reactions were relatively mild and included altered taste, nausea, occasional vomiting and pruritus (itching)."

The report further states that 18 patients in the treated group died during the course of the study, compared with 28 patients in the control group. The mean length of survival for treated patients was 22.9 months, plus or minus 2.6 months, while untreated patients had a mean survival rate of 12.6 months, plus or minus 1.5 months, leading the authors to conclude that patients with HIV infections at high risk for developing *P. carinii* should be considered candidates for sulfamethoxazole and trimethoprim therapy.

Easing drug withdrawal

Thousands of Americans can, no doubt, attest to the soothing effects a waterbed has on sleep. But now researchers at the University of California, San Diego, Medical Center have proposed a new, innovative application for the beds: treating drug-exposed newborns.

The study, published in a recent issue of the *American Journal of Diseases of Children*, reports that infants placed on non-oscillating waterbeds showed a marked reduction in the severity of their problems when compared with other drug-exposed infants placed in conventional bassinets.

Authors Amy S. Oro and Suzanne D. Dixon, MD, studied 30 narcotic-exposed infants, half of whom were assigned to waterbeds and half of whom were assigned to conventional bassinets.

While the infants were comparable in various aspects at birth, the babies on the waterbeds showed significant reductions in irritability, tremors and related central nervous system disorders, and other symptoms commonly associated with drug withdrawal, the authors say. Moreover, the babies treated with waterbed therapy required less medication to control their withdrawal symptoms, and gained weight earlier than those babies in the control group.

The authors conclude that "Non-oscillating waterbeds are safe, noninvasive, inexpensive and effective adjuncts in the care of narcotic-exposed neonates."

How about a glass of water?

Are you ready for this? The next broken arm . . . punctured bladder . . . skull fracture . . . or throat injury you see may be the direct result of an attack by a (gasp!) . . . killer vending machine!

Pentagon officials say that since 1983, seven U.S. servicemen or their relatives have been killed and 39 others injured by vending machines that have toppled over when they were rocked in attempts to dislodge containers or coins. A civilian status, incidentally, doesn't provide any better protection, says the Consumer Product Safety Commission, which puts the number of vending machine victims at four, since 1981.

The problem, it seems, has been ushered in by newer, lighter-weight machines which can accommodate more canned soda in their top sections. This raises the center of

gravity — which, in turn, makes the machine easier to tip over. When full, a machine can weigh 1,000 pounds.

Irate customers, who may have failed to receive a product, or received the wrong change, typically hit or kick the machine initially (hence the broken arms and legs) then, when that fails to produce results, rocking the machine is often the next step.

What can be done to stop this problem? Army officials are recommending warning signs be placed on machines, and are considering anchoring machines to the floor. The Navy, which already bolts its shipboard machines to the deck, is extending the requirement to machines on shore.

Civilians, however, are on their own . . .



Anesthesia for infants recommended

The debate over whether or not male infants should be circumcised has developed a new wrinkle with the report of a study that recommends that infants undergoing the procedure be anesthetized.

The study, conducted by Howard J. Stang, MD, and colleagues at Group Health Inc., and the University of Minnesota, Minneapolis, and recently published in the *Journal of the American Medical Association*, reports that infants who receive the local anesthesia lidocaine prior to the operation show reduced behavioral evidence of distress and blood levels of cortisol, an indicator of psychological distress.

According to the report, 60 newborns who were to be circumcised were divided into three groups — 20 received lidocaine

injections, 20 received saline solution injections, and 20 received no injections. The babies were observed before, during and after the procedure, and samples of blood were taken from each in order to check for cortisol levels.

Their findings: babies in the lidocaine group cried 23 percent of the time during circumcision, compared with babies in the saline and control groups who cried 68 and 71 percent of the time, respectively. Also, blood levels of cortisol were reportedly much lower among lidocaine-treated babies than among unanesthetized babies.

"There is no doubt that circumcisions are painful for the baby," say the authors, who point out that the recommended anesthetic procedure — a dorsal penile nerve block — is a safe and



easy technique for physicians to learn.

They conclude that, "If we are willing to take the time to anesthetize an infant animal undergoing a painful surgery, are we not morally obligated to do the same for the young of our human species?"

New twist to childcare education

Columbus' Diocesan Child Center and Richardson Smith creative design have teamed up to give a new twist to the educational material now reaching new parents.

To combat what it perceives as a literacy problem among young parents — many of whom are between the ages of 15-25 years, and who have had seven or fewer years of education — the Center has created brightly colored posters which use photographs and illustrations to depict the normal abilities in infants in various areas of development. Although captions are used, the meaning of the illustrations is easily inferred without reading the accompanying descriptions.

Project Director Mary Kay McLean explains: "By concentrating on the early years, these materials will help parents with low literacy skills develop reasonable expectations of their children. The parent who has reasonable expectations of his or her child is more likely to develop a nurturing bond with that child." She adds, "A strong parent-child relationship is critical in preventing child abuse and life-long parent-child problems."

Three posters have been developed to date, and there are plans to develop an additional three posters soon. The posters will be distributed at no charge to social service agencies, hospitals — or physicians who may wish to place them in their offices. For further information, contact Mary Kay McLean, Low Literacy Parent Education Director at the Diocesan Child Guidance Center, 840 West State Street, Columbus, OH 43222, (614) 221-7855.

Geriatric suicide

Elderly patients may have a lot more on their minds than the trivial illnesses they are describing to you. According to recent statistics, people over the age of 50 commit 40 percent of all suicides in the United States, even though they account for only 27 percent of the population. And, nearly all first-time attempts succeed in people over 60.

Depression is, by far, the largest factor in these attempts, but it is, by no means, the only one. Other reasons for an attempt include drug abuse, organic brain disease and psychosis.

Suicide is usually attempted after the death of a spouse, especially within the first few days of mourning — or on the anniversary of the death, so these may be times when it's wise to be a particularly patient listener.

If an attempt has been made by an elderly patient, several things might help — including changing the patient's environment, helping the patient find a new companion, prescribing appropriate medication, following up on the patient's progress . . . and, of course being a good (and sympathetic) listener.



Alzheimer's — a costly problem

Recent studies delving into the cost of Alzheimer's disease and related dementias show that \$88 billion was lost in 1985 due to these illnesses.

Cost estimates were based on patients who are 65 or older, and who suffer from Alzheimer's disease, multi-infarct dementia or mixed cases of both. According to the study's investigators, direct patient care costs, including nursing home care and social services were \$13.26 billion.

Added to that figure is the price of in-home care, typically custodial

in nature — i.e., supervision, assistance with daily tasks and dressing. Indirect costs (provided mainly by family members) comes to about \$31.46 billion.

Finally, economic loss, due to loss of productivity during the extended period illness and premature death is factored in . . . \$43.17 billion.

All of the estimates are on the conservative side, say the researchers, who point out that such considerations as stress-related costs are not reflected in the final figure.

COLLEAGUES

DOUGLAS A. RUND, MD, Columbus, has been elected to the board of directors of the American Board of Emergency Medicine . . . **JAMES E. LUNDEEN, MD**, University Heights, has been named medical director of PromptCare Medical Center . . . **LEONARD J. JANCHAR, MD**, a Marion pediatrician, has been named president of the Marion County Board of Health . . . **HENRY D. ROCCO, MD**, a Newark orthopedic surgeon, has been selected to serve as on-site physician for the U.S. Olympic Training Center in Colorado for two weeks this summer . . . **HENRY GAILLARD, MD**, Cincinnati, has been named medical director of the department of emergency medicine at Jewish Hospital . . . **RAYMOND B. GILES, MD**, New Philadelphia, has been appointed to the Community Mental Health Board of Tuscarawas and Carroll counties . . . **JOHN HUTTON, MD**, Cincinnati, has been named dean of the University of Cincinnati's College of Medicine . . . **JOHN HOLMAN, MD**, Steubenville, has been elected president of the medical staff at Ohio Valley Hospital . . . **JEROME KLEINERMAN, MD**, New York, director of the department of pathology at Cleveland

Metropolitan General Hospital, has received the Bicentennial Medallion of Distinction from the University of Pittsburgh . . . **FRANK R. NOYES, MD**, Cincinnati, has been honored by the American Orthopaedic Society for Sports Medicine for his seven-year term as chairman of the society's research committee . . . **PRASAD KAKARALA, MD**, Tiffin, has been elected president of the medical staff at Mercy Hospital . . . **JOSEPH F. ALEXANDER, MD**, Akron, has been appointed head of Allergy-Immunology at Northeastern Ohio Universities College of Medicine . . . **JAMES A. LEHMAN, MD**, Akron, has been elected vice president of the American Cleft Palate Association . . . **LEON T. SACKS, MD**, Akron, has been honored by the Ohio State University and the Summit County Medical Society for 50 years of medical practice . . . **STANLEY E. POLLACK, MD**, Euclid, has been named director of obstetrics and gynecology at Meridia Hillcrest Hospital . . . **HOWARD S. MADIGAN, MD**, Sylvania, has been appointed director of medical education at the Laser Institute of America . . . **TERRANCE A. PUET, MD**, Vienna, has been appointed assistant medical director at Hillside Hos-

pital . . . **THOMAS R. BULLOCK, MD**, Columbus, has been named medical director of Ohio State University's MedOHIO physician care centers in Columbus and Newark . . . **JAMES E. FLEMING, MD**, Cleveland, has been presented with an honorary Doctor of Law degree from Youngstown State University . . . **THEODORE E. WYMYSLO, MD**, Dayton, has been selected as the 1988 honorary faculty member of the Epsilon Chapter of Ohio of Alpha Omega Alpha (AOA) Honor Medical Society . . . **LORREE TAYLOR, MD**, Toledo, has been appointed medical director of the Toledo Hospital Alcoholism Treatment Center . . . **HERBERT ROSENBAUM, MD**, Vermilion, has been appointed medical director of St. Joseph Hospital and Health Center . . . **ROBERT J. WHITE, MD**, Cleveland, director of neurosurgery at Metro General Hospital, has been named "National Health Professional of the Year" by the Visiting Nurse Association; **ROBERT J. IZANT, JR., MD**, Cleveland, a pediatric surgeon at Rainbow Babies and Childrens Hospital, has been named "Greater Health Professional of the Year."

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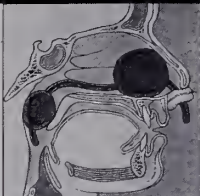
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CUMULATIVE INDEX

OHIO MEDI-SCENE

Traveling patients . . . Charles S. Nelson — in memoriam . . . OSMA's new president . . . new herpes vaccine . . . acting classes for the disabled . . . a walk down Easy Street . . .

What should you tell your traveling patients?

It's June, so you might as well face it.

Sooner or later, you are going to come toe-to-toe with a rapidly-increasing segment of our population — the traveler. You know — those lucky people who have decided to forsake jangling telephones, nerve-wracking freeways and all their routine, and daily tasks for the lure of some exotic locale, located halfway around the world. Sooner or later, they show up in your office — for the shots, the Dramamine and that bit of advice that may help them avoid the infamous "traveler's quickstep."

If that's *all* you plan to give them, however, maybe you should rethink your global responsibilities.

The world, according to Robert A. Salata, MD, director of the Travelers' Clinic at the University Hospitals of Cleveland, is not necessarily friendly to globe-trotting tourists — especially not to the eight million or so who travel each year to Third World countries.

"There are special health risks in all of the developing countries," he says, naming Central Africa ("a popular place to go for a safari"), India, South America, Central America, Southeast Asia and the Orient ("more

specifically, China") as places where travelers must take special precautions.

"The risks are fewer for European travelers," he adds, but warns that vigilance should not be relaxed. The risks are still there. "You can still get traveler's diarrhea in Russia," he comments.

Patients who are knowledgeable consumers will know enough to come into your office in plenty of time to allow inoculations to be given, and have questions answered, but Dr. Salata thinks physicians, especially those in primary care areas, need to be more aggressive about discovering their patients' travel plans — and

on brushing up on the advice they intend to give.

"According to one *JAMA* study," says Dr. Salata, "only 50 percent of the travelers visiting Third World countries sought medical care, and of the 50 percent who did, only 14 percent got the correct advice."

The problem, of course, is that most primary care physicians don't have the type of information they need to give tourists readily available to them — and, in all fairness, the field of global health is moving so quickly that even the Travelers' Clinic can find it difficult to keep up-to-date with the latest health "hot spots."

Consequently, says Dr. Salata, their physicians rely heavily on the services of an international organization known as IAMET — the International Association for Medical Assistance to Travelers — as well as the World Health Organization and the Centers for Disease Control, to keep knowledgeable about health conditions around the world.

"But every doctor should have a copy of the CDC's publication 'Health Information

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OHIO MEDI-SCENE

What you should tell your traveling patients . . . *continued*

for International Travelers' in their offices," says Dr. Salata.

OK — so what if you learn a patient of *yours* is planning an African safari? What should you

do? The best thing, says Dr. Salata, is to arrange for a pre-travel consultation with that patient. If you're planning to give inoculations at the same time,

arrange to have the consultation four to six weeks prior to the trip to allow optimum time for the inoculations to work.

Then, because no immunization is 100 percent effective, reminds Dr. Salata, provide the patients with some sound, commonsense advice.

You might begin, for example, by discussing any chronic medical problems the patient has. Travelers with chronic health problems have become more and more prevalent in our society as the number of globe-trotting senior citizens increases. It is especially important, says Dr. Salata, for these patients to remember to pack their medical records, along with the shorts and sunscreen.

"We can also provide them with a list of English-speaking doctors before they go, so if they do have health problems abroad, they will have someone to turn to," he comments, adding that travelers with pacemakers, for example, are frequently interested in lists of foreign cardiologists.

If a tourist *does* experience a medical problem abroad, and has no list of recommended doctors, then Dr. Salata recommends the traveler try one of three things.

"They can go to the American Consulate or Embassy for a list of recommended physicians, or they can ask a travel agent or hotel manager for such a list, as these people frequently cater to Americans."

Finally, Dr. Salata suggests that the traveler go to a missionary

Who, what, when, where, why and how: the inoculation dilemma

The problem with inoculations, says Dr. Salata, is that often, not even physicians know which ones to give. As a result, many travelers go abroad with only those inoculations which are required by law — *not* the ones best suited to the destination or to those specific-to-the-area health problems which the tourist is likely to encounter.

Standard inoculations should include typhoid, tetanus and gamma-globulin, says Dr. Salata — and a yellow fever vaccine is also a good idea, especially for those travelers going to Central America or Africa.

"The yellow fever vaccine is safe, and it's good for 10 years," he says. The drawback is that the vaccine can only be administered in authorized centers. In Ohio, that includes: Akron General Medical Center; Akron City Health Department; Canton Health Department; Case Western Reserve University; MedNet Travelers' Clinic in Cleveland (as well as the one at UHC); Mahoning County Health Department; OSU's Family Practice Clinic; Montgomery County Health Department; and

the Medical College of Ohio at Toledo (contact the CDC or the UHC Travelers' Clinic for a complete list).

Cholera is not a good vaccine, says Dr. Salata, as it lasts only six months, yet it may be needed (or even required) by those traveling between countries. And while the typhoid vaccine admittedly has bad side effects, it is a necessary inoculation, he reports — especially for those travelers going to Mexico, "where even five-star hotels are suspect."

"The efficacy rate of the typhoid vaccine is 60 to 80 percent and lasts three years," says Dr. Salata. And, an oral vaccine may soon be available.

Tetanus still exists in tropical areas, so Dr. Salata recommends it, as well as a polio vaccine — "especially for those over 40 who have negligible antibodies in the blood." A malaria vaccine is also important, he says, as malaria is striking an increasing number of tourists.

For further information on what inoculations to give and when, contact the CDC or your local health department. — *Karen S. Edwards*

hospital, where there is usually a better supply of drugs and where the physicians are likely to be European or even American-trained.

Of course, every savvy traveler should also keep a travel health kit close at hand — filled with any prescription medication needed (“And make sure,” says Dr. Salata, “that this medication is well-labeled and carried rather than packed — you never know what might happen to the luggage”), sunscreen, insect repellent, and any other medication the patient may have been given — i.e. for motion sickness or traveler’s diarrhea.

Actually, the best way to avoid the latter, however, is not necessarily through medication, but through careful eating and drinking habits, he notes.

“Oddly enough, only 10 percent of the cases of traveler’s diarrhea which occur are due to water. Food is, by far, a more likely vehicle of transmission, especially leafy vegetables, like salads, that may have been washed in local water, vendor food and airplane food — much of which is supplied locally.

“We tell travelers that anything boiled, peeled or cooked is safe,” he continues, which means coffee and tea are OK as are carbonated beverages (as long as they’re not bottled locally) and alcohol.

“Anything boiled, peeled or cooked is safe to eat.”

“Watch out for the ice cubes in the drinks, however,” Dr. Salata says — and the water used to brush teeth.

Pre-travel advice also includes what to do for jet lag and high-altitude sickness — and how to avoid insect bites (through use of repellent and netting). Globe-trotters are also warned not to do any fresh-water swimming in areas



Cincinnati opens travelers’ clinic

Travelers from the Cincinnati area won’t have to travel far for their international health news. This past April, an International Travelers’ Clinic, similar to the one at the University Hospitals of Cleveland, opened in Cincinnati at the University Hospital’s Family Medicine Center.

The clinic was set up by Jeffrey Heck, MD, a family practitioner who received some of his experience in international health firsthand as a doctor in an African mission hospital. There, he noticed American tourists falling ill to diseases or infections they knew nothing about.

The International Travelers’ Clinic will provide American travelers with all the information they need on medical care and disease prevention before they leave on their overseas trip, including necessary vaccinations, health precautions and safety requirements (according to Dr. Heck, traffic accidents remain the number one killer of American tourists abroad). Travelers will also receive a list of English-speaking physicians based in the country they’re heading for, and a lesson in how to get involved in a health-care system that is not their own. — *Karen S. Edwards*

like Africa, Puerto Rico and the Caribbean where a parasitic disease known as schistosomiasis can be transmitted.

AIDS, too, has become part of the pre-travel consults.

“AIDS is a problem in 150 countries outside the United States — where approximately 25,000 cases are known to exist,” says Dr. Salata.

At least 17 cases of AIDS have been discovered in travelers, most of which have been transmitted through contact with prostitutes, although a few have been due to infected needles and blood product exposure.

Travelers are also notified of HIV II — an illness similar to AIDS which has recently begun to

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OHIO MEDI-SCENE

What you should tell your traveling patients . . . *continued*

surface in West Africa.

Dr. Salata admits that blood transfusions in Third World areas are risky at best — “the blood supplies can’t be trusted,” he says.

So what does a traveler do if he or she is involved in an accident?

“It’s possible to make arrangements to be airlifted out of the area and taken to a European country where the blood supply is screened,” suggests Dr. Salata.

A more practical idea, however, is to search the party you’re traveling with for blood donors.

“Travelers should know what

their blood type is. Then, if an accident occurs, a match might be found from others traveling in the same group.”

Finally, Dr. Salata believes a post-travel exam should be conducted if a tourist has spent more than three months in a developing country.

All physicians, however, should be aware of international health problems — just in case that unexplained fever or those mysterious symptoms that show up in your office turn out to be something like malaria — certainly

a treatable illness — if it is properly diagnosed.

“Ten percent of mortality in Americans can be attributed to either a misdiagnosed illness, or an illness for which inappropriate treatment was prescribed,” says Dr. Salata. “That’s why physicians should know where to seek information.”

So brush up on the facts — and stand ready. Those globe-trotting tourists, no doubt, will be making that most important trip — the one to your office — soon. —

Karen S. Edwards



Charles S. Nelson — In Memoriam

Editor's note: *Charles S. Nelson, former executive director of the Ohio State Medical Association and one of the nation's first medical society executives, died this past March in Columbus, at the age of 90. He is survived by his wife, Josephine. The tribute that follows provides those who knew him — and those who didn't — a closer look at the man and his accomplishments. As our author puts it: "I have tried to describe him as he lived."*

Charles S. (“Chuck”) Nelson was the heart of the Ohio State Medical Association for the three decades he served as its chief executive, 1935-64.

During those years, the nation endured a great depression and the association was called upon to assist public agencies with programs to provide medical care to many Ohioans without resources.

It was early in this period that the OSMA acted on the beginnings of the medical professional liability problem by hiring a lawyer, Wayne Stichter, to defend members who were sued for medical malpractice.

The American Bar Association sued the OSMA for “unauthorized practice of law” and a consent decree, signed by OSMA, ended the program.

The association and Nelson then

faced the problems of World War II and a program was developed to make certain that no area of the state was without a physician's care when half of Ohio's medical doctors went to war.

At the end of the war, the association assisted the returning medical officers in finding practice locations and returning to civilian pursuits.

Always on the leading edge of problem-solving, the association, with Nelson's guidance, established in 1945 the Ohio Medical Indemnity Inc., "The Doctors' Plan," primarily to assist individuals and small employee groups in obtaining medical/surgical insurance. At that time, existing insurance underwriters were interested in large employee groups where there was a better risk spread.

Ohio Medical Indemnity, Inc.,

Charles S. Nelson was ruggedly honest, extremely conscientious and unhesitating in the expression of opinion.

was accepted as a Blue Shield plan and grew into a huge enterprise, insuring not only individuals and sued groups, but also the employees of large Ohio and national companies.

Nelson served as an officer of the company, without pay, from the beginning until his retirement.

The company still operates successfully, but is a mutual rather than a stock company, and has no medical participation.

Nelson built the OSMA from an organization with five employees with dues of five dollars a year, into a strong, well-staffed organization with the ability to represent physicians competently and well.

When he retired in 1964, the organization was well-prepared to

face a whole new set of problems involving the establishment of the Medicare/Medicaid programs.

Charles S. Nelson, as a person, was ruggedly honest, extremely conscientious and unhesitating in the expression of his opinions, especially on matters pertaining to medicine.

He was an excellent writer, having worked for President Warren G. Harding on the *Marion Star*, and as telegraph editor of the old Columbus *Citizen* after graduation from the OSU School of Journalism.

He was proud of his ability in written communication, and spent many hours with his old standard typewriter, a cigarette burning scars in the old typewriter table, while he hammered out suggested policy papers for the Council; Committee Minutes; Council or House of Delegates Minutes; and articles for the *Ohio State Medical Journal*.

He wrote several editorials for the "In Our Opinion" page of the *Journal* each month. They left no doubt as to where he and/or the OSMA stood on issues of the day.

He founded the *OSMAgram*, the OSMA newsletter, and wrote and edited the entire publication from its inception until his retirement.

Nelson unobtrusively took the Council Minutes "newspaper style," making a few notes on each issue as he participated in the general discussion. After the meeting, he used his notes to produce the minutes.

One day, during the Council's discussion of a particularly important policy, Richard L. Meiling, MD, asked, "Is anyone getting this down?" The explosion which followed was "worth the price of admission."

Fiercely loyal to the OSMA and its members, Nelson fought hard before state agencies and the Legislature against "bad medical regulations and laws" for good ones.

His serious nature and his willingness to fight for what he

thought was right often masked his fine, underlying appreciation of humor.

For example, one day, as he was testifying before an Ohio House of Representatives committee on a bill to exempt Christian Science

Without hesitation, Nelson replied . . . "Yes, sir! I pray every time the Legislature goes into session."

practitioners from the healing arts laws, a legislator asked, "Mr. Nelson, do you believe in prayer?" Without hesitation, Nelson replied, "Yes, sir! I pray every time the Legislature goes into session!" Even the committee members joined the laughter.

As chief executive, Nelson was demanding of his staff, yet more demanding of himself.

He was firm and businesslike in his staff relationships and he found it difficult to tolerate incompetence. He was feared by the younger staff members, but was a compassionate friend if they needed help.

Respected and admired as a professional leader, Nelson was a founder and an early president of the American Association of Medical Society Executives; President of the Ohio Society of Association Executives; Chairman of the Advisory Committee to the Communications Director of the American Medical Association; President of the University Club of Columbus; and was the recipient of many honors and awards for achievement.

Nelson was the third chief executive of the OSMA. The first was George Sheridan, also a newspaperman who served from 1913 until 1919. Don Martin, who was chief executive from 1919 until 1935 hired Nelson from the

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OHIO MEDI-SCENE

Charles S. Nelson . . . continued

Columbus *Citizen* in 1928.

Nelson succeeded to the top position in 1935 and hired, as his assistant, a genial Scot, George H. (Scottie) Saville, who succeeded him in 1964. The two men were a fine leadership team whose talents were complimentary. They worked together with mutual respect for 30 years.

Nelson was a fine family man who had great love and respect for his wife Josephine.

He was an ardent fisherman and golfer, but, unfortunately, he was unable to follow these hobbies in

the latter part of this life, due to an illness which severely restricted his physical activity.

He continued to follow the activities of the association through the *Journal* and the *OSMAgram*, but seldom returned to the office, because he did not want to "meddle." He felt that he had trained his successors well and that it was up to them to make their own decisions. — *Hart F. Page*, Executive Director Emeritus of the Ohio State Medical Association, and the Association's official historian.



Taking a shot at herpes

A new vaccine being tested at Children's Hospital Medical Center in Cincinnati should be good news for the estimated 20 million individuals in the U.S. with herpes.

Lawrence R. Stanberry, MD, PhD, associate professor of pediatrics in the Division of Infectious Diseases and head of the vaccine research, says the killed or subunit vaccine has reduced the number of herpes occurrences in lab animals by approximately 50 percent.

Dr. Stanberry believes the vaccine works by "augmenting the host immune system."

Ideally, the vaccine should prevent the animals from acquiring initial infections, and thus should reduce the total number of herpes transmissions. The vaccine is currently being tested on guinea pigs, the standard animals for antiviral testing, he explains.

According to Dr. Stanberry, "The vaccine should have an

Donavin A. Baumgartner, Jr., MD: OSMA's New President



Donavin A. Baumgartner, Jr., MD, was installed as President of the Ohio State Medical Association last month in ceremonies held during this year's Annual Meeting in Cincinnati.

Dr. Baumgartner practices surgery at St. Luke's Hospital in Cleveland, where he also serves as the Medical Director of Emergency Services, and as the Director of its Division of Trauma in charge of the Level I Trauma Center.

The August issue will feature a profile story on him — detailing his active participation in all levels of organized medicine, as well as those goals he has set for himself as OSMA President. This issue contains his first President's Page (page 423).

incredible impact on all kinds of herpes viruses — genital herpes, fever blisters, herpes keratitis and herpes encephalitis.”

In addition, the vaccine should reduce the risk of herpes occurrence during pregnancy and prevent mothers from acquiring the virus in the first place, which are key concerns among the Children’s researchers.

Dr. Stanberry emphasizes that the vaccine is not a cure. “The vaccine won’t eliminate the virus, but it will handle it better,” he explains.

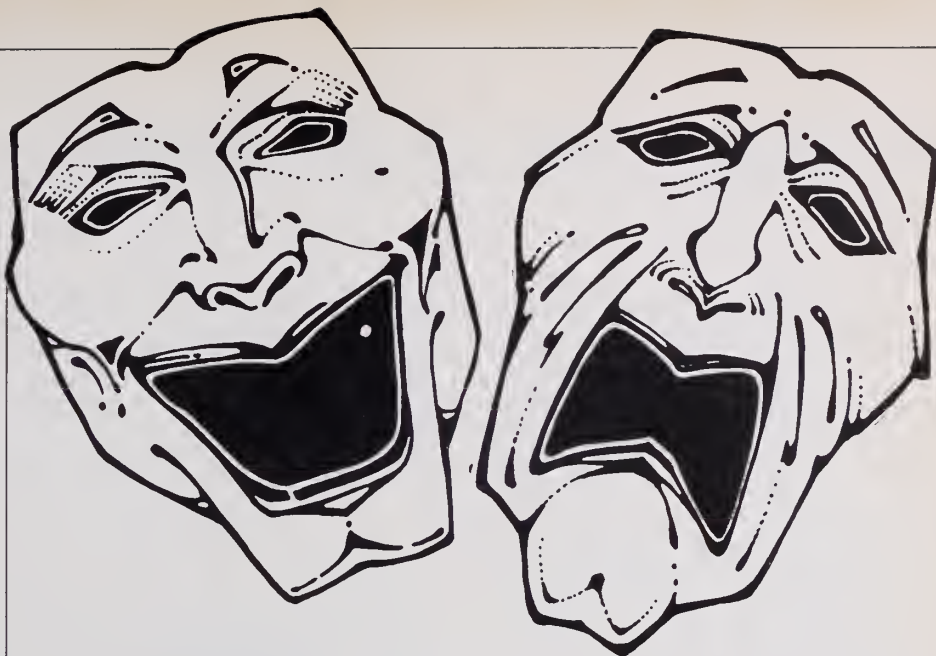
“The vaccine should have an incredible impact on all kinds of herpes viruses . . .”

He compares the vaccine to *acyclovir*, a current herpes medication on the market, pointing out that they both reduce frequency and severity of outbreaks. Whether the vaccine turns out to be more effective than its prototype — in treatment, convenience and cost — remains to be seen.

For now Dr. Stanberry sees the vaccine’s effectiveness first in terms of *treatment* of herpes, but is also optimistic about its prevention potential.

Children’s Hospital researchers are presently looking for the best route of administration and appropriate dose response. Dr. Stanberry believes the vaccine should be ready for testing on individuals with herpes sometime this year.

In the near future, Dr. Stanberry has his sights on more refined and efficient second-generation vaccines. For the time being, however, there’s at least one more weapon being leveled against herpes — which is good news for everyone. — *Deborah Athy*



The play’s the thing . . . or is it the players?

The ad had run in the paper before: “Beginning acting classes, Cincinnati Playhouse.”

Typically, the applications received were from a small cross-section of people — lawyers, for example, whose careers hinged on their ability to sway a judge and/or jury; business executives, anxious to make their presence felt in a boardroom; and, of course, the usual assortment of would-be actors and actresses.

This, however, marked the first time anyone with cerebral palsy had ever applied.

“I wasn’t sure what to do,” admits Laura Fine, Acting Academy Director at the Cincinnati Playhouse. She knew she had an obligation to the applicant — “I didn’t want to discriminate because of her disability,” she says.

Yet what about the rest of the class? How would *they* work with someone who was physically disabled? After all, these were acting novitiates — with a great deal to learn . . .

Actually, it’s not all that unusual, these days, for someone with a physical handicap to *want* to get involved with bright lights and curtain calls. In recent years, society has begun to see more and

more physically disabled people depicted on stage and screen — both movie and TV.

“It probably began with the movie ‘Coming Home,’ ” says Steven Scheer, MD, Director of Physical Medicine and Rehabilitation at the University of Cincinnati Medical Center. That movie featured actor Jon Voight in a wheelchair, portraying a disabled Vietnam War veteran.

Shortly after that, Broadway audiences were introduced to different types of disabilities as they flocked to such plays as “Wings,” “Whose Life Is It Anyway?” and “The Elephant Man.”

Then, with the movie “Children of a Lesser God,” a new wrinkle was added. This time, the actress who portrayed a hearing-impaired individual was actually hearing-impaired.

Since then, more and more actors and actresses with physical disabilities are finding work . . . on commercials (McDonald’s broke the ground in this area with its depiction of a hearing-impaired couple on their way to a beach) . . . in comedy (a comic with cerebral palsy is cracking them up at big-name clubs) . . . and on television (a paraplegic had a supporting role this season in the new series “Wiseguy”).

In retrospect, then, the fact that

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OHIO MEDI-SCENE

The play's the thing . . . continued

Fine was now faced with her first physically-disabled applicant doesn't really seem all that unusual. It may have been just a matter of time.

Still, for Fine there was that dilemma — that mixed sense of obligation to the applicant, and to the able-bodied class the applicant wanted to join.

Finally, she found a solution.

"I invited her to audit the advanced acting class."

The advanced class was larger, more confident of its abilities and therefore more adaptable to this situation than the class of beginners, Fine explained.

The applicant, Barbara, came every week — participating when she could, observing when she could not. It turned out to be a wonderful experience for everyone, Fine says.

Yet, the acting teacher was still not satisfied that she had done everything she could to help Barbara. She wanted to do something more . . .

"We wanted people to become familiar with seeing the disabilities and looking beyond them."

When Dr. Scheer was still a student at Northwestern University, he was no stranger to the footlights himself. There were



Steven Scheer, MD

productions of Gilbert and Sullivan in which he appeared . . . some community theater . . .

Eventually, however, medicine claimed him. He became the medical director of a rehabilitation hospital in Chicago, yet it wasn't long before he became involved in a pet project which combined both of his interests. The project was a play which focused on physical disabilities — or, at least, the general public's perception of them. Physically disabled actors and actresses played the parts.

"We wanted people to become familiar with seeing the disabilities and looking beyond them to the person," says Dr. Scheer. The play



Laura Fine

was composed of a series of vignettes — some dramatically serious, some full of black humor. For example, there was the scene involving a pregnant woman in a wheelchair.

"My obstetrician is worried about how he's going to get the little wheelchair out," the disabled actress joked.

It got a laugh — while opening wide the doors of public misconceptions and myths about the physically handicapped.

The play accomplished its purpose, says Dr. Scheer. It showed disabled people doing human things — and that's one message he would like to see delivered to

the Cincinnati community as well. In fact, that's what brought Dr. Scheer into contact with Laura Fine in the first place.

"I do some free-lance direction, and he asked me whether or not I would be willing to participate in the project," she says.

She agreed to read the script and did — providing him with some necessary professional feedback. But while the play continues to wait for funding support (Dr. Scheer is working with the National Easter Seals toward that end), Fine decided to involve Dr. Scheer in a project of her own — completely independent of the Playhouse and her acting classes there.

"I called and asked him if I were to volunteer to teach an acting class for the physically disabled, would his department coordinate it?"

The answer was yes, and for six weeks this past spring, Fine led six women and one man — with a variety of impairments — through an acting class specifically designed to match their capabilities. She admits it has been an eye-opening experience.

"The first day I met the class, I threw the lesson plan out the window," she now recalls.

Still, many of the activities they did were not dissimilar from those done by able-bodied students in more typical acting classes. There were physical and vocal warm-ups, guided imagery work, relaxation exercises with visualization techniques and creative storytelling.

Some activities, however — like the mirror exercise — had to be adapted.

"In the mirror exercise, one student faces another, making eye contact," explains Fine. One of the students then begins to grimace or make a face that is instantly copied by that student's "mirror image."

In an able-bodied class, Fine explains, these same imitative

gestures would then be done using different parts of the body, but her physically disabled class, after perfecting their facial expressions, skipped this more physical part of the exercise. After all, there were *other* exercises to try — other techniques to master.

"I (tried) to find ways to give them experiences while keeping their handicaps in mind," says Fine.

Expectations for the class were also kept to realistic levels. No one, says Fine, was expected to come out of the class a "professional" actor — a skill she adds, that takes some 20 years to learn.

However, that "professional" status *is* achievable.

"If they can learn to communicate to an audience above their physical limitations, then, yes, it's possible," she says.

For this class, however, Fine and her students were happy to settle for less lofty (and maybe in the long-run, more worthwhile) goals — goals like increased communication skills, creativity

and a newfound awareness of self.

That's the lesson that needs to be learned, agrees Dr. Scheer — and that's the reason he promotes the class to those patients he works with.

"It's a confidence-builder," he says. "It's that ability to present yourself with a feeling of 'why not?' The outside shell may be different for these people, but inside, they're the same, and they need to be able to get that across to others."

"There is a tendency to view the physically disabled as mentally impaired as well," adds Fine. "But it's not true. These people are very bright, very intelligent. Acting, however, can give them a greater sense of self."

If interest continues in the classes, Fine will continue to conduct them and, eventually — who knows? Even if Broadway or Hollywood isn't necessarily holding its breath for this kind of specialized acting talent — Dr. Scheer (for the sake of his pet project) is. — *Karen S. Edwards*

A walk down Easy Street



You can hop on the bus. Take a walk around the block. Stop off at the bank and then head over to Gold Star Chili for lunch. On your way home, you might stroll by Kroger's for some last-minute purchases or take a sit-down in the park.

All these things can be done on Easy Street. Directions? Just head toward Bethesda Hospitals in Cincinnati, because Easy Street is a miniature city built within the hospital.

Easy Street is a prescribed therapy for patients with cognitive or physical problems — such as a stroke, head or spinal injuries, amputees, accident victims — to help them readjust to the rigors of the everyday, explains Jeanne Cranley, Director of Physical Rehabilitation Services at Bethesda.

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OHIO MEDI-SCENE

A walk down Easy Street . . . *continued*

A walk down Easy Street can take 10 minutes or several hours, depending on the patient's destination and goals — walking, memory, math, reaching or building confidence.

"There's nothing like Easy Street in Cincinnati or in the whole state. Patients come to us because they can't go home. Many are afraid to try the outside world," says Cranley. Stepping out first on Easy Street can help ease this fear and pave the way to independence for these patients, she adds.

Easy Street, Ohio is the 10th of its kind in the country. An occupational therapist and an architect hatched and franchised the concept after finding success with the project.

The concept has also met with success in Cincinnati. "The concept was so different," Cranley explains. "The business community warmed to it. They could actually set up miniatures of their businesses. The idea was exciting not only to us, but to them."

"Patients come to us because they can't go home . . ."

Easy Street consists of seven modules, size 10' x 10', set against photo mural backgrounds that add depth and realism to the scenes.

Some of the stop-offs along Easy Street include:



Top: Bethesda Hospital's "Easy Street" staff helps a patient become comfortable in an office setting.



Below: Shopping in "Easy Street's" grocery facsimile.

• **The Fifth Third Bank.** This mini-bank comes complete with counter, velvet ropes, name plates, checking and deposit slips, IRA forms. If there's no time for transactions with a bank teller, one can stop at the Jeannie machine, which is programmed with a dummy account, play money, code numbers and cards to make the transactions more authentic. Skills to be learned include cognitive processes with money, forms, transactions; one-hand maneuvers while holding purse, cane or walker; and maneuvering oneself through the ropes with wheelchair or walker.

• **Gold Star Chili.** Napkins, menus, Johnny Bench postcards (the restaurant's spokesperson), cups and edibles make stopping off for lunch authentic. Patients get practice reading menus, ordering, walking with a tray, figuring tips and eating in public.

• **The Cafe.** The background mural really sets the stage — black and white checkered floor, a neon cafe sign, metal napkin holders and red stools.

• **The Office.** The thought of going back to the office can cause the jitters for many patients. This module reintroduces patients to this idea and to the activities such as filling out paperwork, alphabetizing, taking messages, using a calculator, maneuvering between desks, using a swivel chair and answering the phone.

• **The Kroger Garden.** The background mural makes the rows of fruits and vegetables appear just an arm's length away and enables the patients to practice scanning for prices in the distance and reading signs above the aisles. This mini-mart has many of the fixtures of a regular grocery, including cash register, hanging scale to weigh produce, canned food and a grocery cart.

• **Bus Stop.** Mural of a bus with actual bus steps. Enables patient to practice climbing the rather steep steps, read schedules, find

correct change and balance packages.

• **The Car.** A blue Ford Cougar is parked next to a parking meter. Patients practice getting in and out of the auto, putting coins in the meter, opening the car doors, reading maps and judging safety situations. A mural of a garage completes this scene.

• **And last but not least,** the Park. After all these stops, a person needs a place to rest. This module has the flavor of the outdoors with a park bench, silk tree, street signs and crosswalks.

The businesses really contributed to make the modules more realistic, Cranley continues. Kroger, for example, contributed the grocery module and continues to supply plastic bags, grocery bags, unit pricing labels and empty brand-name boxes.

"The businesses did what they could to personalize the modules even more," she continues. "The response has been wonderful."

Easy Street doesn't always fit its name the first time around. It's meant to challenge the patient just as the real world does. Easy Street is full of ups and downs; it has curbs, turnstiles, heavy doors, streets without ramps and narrow walk areas.

Some patients have trouble conceptualizing how it will be the first time they go shopping or return to work. Easy Street allows them to go through the motions beforehand, which gives them reassurance.

"There's a real need for the patient to feel confident and to feel safe so they can go back and have a quality life. You don't have a quality life if you're stuck at home," Cranley points out.

But it's not just the patient who has doubts; the family sometimes wonders, I don't know if he or she can handle that . . . Cranley says Easy Street helps to demonstrate the patient's abilities and difficulties.

"Easy Street is an expectation

that we (the therapy team) have that the patient will get well and be independent and return to normal living. In fact, we intend to make sure they can do this," she says.

Maybe this confidence rubs off on the patients, Cranley says, and "they start to see the light at the end of the tunnel."

Easy Street opened its doors to the public in March, after word

"Easy Street is an expectation we have that the patient will get well."

got around about a miniature city building up somewhere inside the hospital.

The response from the public, the businesses and from the patients themselves has been wonderful, Cranley says. "'Wow' is usually the first word out of people's mouths. The patient is so surprised. They didn't realize how nervous they were to go out and do these things. Many secretly wondered if they'd ever be able to go to the grocery or even sit on a park bench again."

One woman, a double amputee, thought the park bench was the absolute highlight, Cranley continues, because she had always loved to go to the park and people-watch.

The patient thought it was over for her, not being able to do something she had loved to do. But the Easy Street concept enabled her to practice using her wheelchair without crowds, bad weather or fear of failure. She could try it over and over until she got it right, says Cranley.

Easy Street may not start out as a piece of cake for some patients, but it gives credence to the expression: practice makes perfect.

— *Deborah Athy*



“To know how to grow old is the master work of wisdom, and one of the most difficult chapters in the great art of living.” — *Henri-Frédéric Amiel*

The Elderly and Society: The Quest for Independence

By Deborah Athy

A general theme that emerged among the speakers at the Technology and Aging Conference held recently in Columbus was the recognition that the elderly want more than housing, companionship, medical care, and low- and high-tech gadgetry. They want something *in addition* to these things. Something more intangible, and yet vital to their self-esteem and fulfillment. They

want to retain their independence.

It is true that the elderly often have special needs and require differing levels of assistance in their lives. But as the conference speakers suggested, their assistance shouldn't come at the cost of their ability to make choices about their lives. Thus a balance has to be struck between the elderly's need for support and their need for autonomy.

Continued on page 445

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You don't have time to waste on medical writing that is cluttered with complicated statistics and data. Depend on *Postgraduate Medicine* to provide you with clearly written, well-illustrated articles on matters of practical importance in your daily life.



The majority of the nation's elderly, if given the choice, prefer to stay in their homes.

One area in which this becomes evident is in housing, an aspect examined at the conference which was co-sponsored by the Ohio State University Department of Industrial Design, the Division of Nursing Development at University Hospitals, and the Battelle Endowment for Technology and Human Affairs.

M. Powell Lawton, a psychologist and the Director of Research at the Philadelphia Geriatric Center, asked the conference participants: Do the elderly, for the most part, want to stay in their own homes or do they want to move? Do specialized environments, those housing units built specifically for the aging, help or hinder? Do these housing units promote age segregation? And, finally, what's the place of supportive services in elderly housing?

Lawton, the past-president of the Gerontology Society of America, admits these aren't new questions. But, he says, an optimist might point out that these issues have proven themselves relevant time and again — a view he shares.

In any case, there are really no clear-cut, ready-made answers to most of these questions, considering the diversity in the elderly population as well as in housing units. But Lawton does venture an opinion on one question. It does appear, he says, that the majority of the nation's elderly, if given the choice and if medically and financially able, prefer to stay in their own homes.

It's a myth that most elderly

people pack their bags and move to Florida when they hit retirement age, he says. Migration to retirement areas is on the increase, but this is reserved primarily for those considered to be the "privileged" elderly — usually those who are economically secure, married and in good health.

Generally speaking, younger people move six times more often than their older counterparts, he continues. When the elderly do move, it's usually due to poor health, and they tend to remain in their own vicinity.

About 10% to 12% of the elderly live in public housing units, which can be anything from a massive high-rise to a small apartment complex. Some are attractive, innovative and located in good areas, while others are poorly designed and in need of extensive upkeep.

Complexes should be designed with the elderly in mind and should promote growth and positive autonomous behavior, says Lawton. While there can be positive gains in mental health with planned activities and companionship, often these gains are short-lived.

Lawton explains that the average age of a tenant moving into a housing unit is 72. But, he says, as the tenant grows older, problems begin to surface. "The environment of the units will perceptibly age, and there is a clear dilution in social exchanges."

Therefore, what was initially adequate and beneficial is no longer satisfactory for the individuals. Lawton suggests



on-site health-care management as one way to meet the aging tenant's needs.

"Designers should be looking 10 to 15 years ahead to fit the needs of the elderly," he says. The architects of the future need training and sensitization to design units that promote social interaction and safeguard health even as the patrons age.

Questions have also been raised about the issue of age segregation in the housing units — a sore spot with Gray Panther activist Maggie Kuhn, who also took part in the conference. Age segregation has met with a number of solutions, from building elderly housing near college dorms to constructing meeting areas and benches outside aging complexes. For now, it's an area still under discussion, Lawton says.

But the crux of the elderly housing issue is that two-thirds of the aging don't want to move into these establishments in the first place. They prefer home sweet home.

An overriding feature is the attachment to the neighborhood and the home itself. The individual gets to know the area — the shopping, transportation, parks — and develops a social network. "One wants to maintain some kind of tie to the things one knows well," he explains.

Paul Windley, a professor of architecture at Kansas State University, takes the attachment to the home a step further. "The elderly often see their dwelling unit as an extension of themselves. Many would go to any lengths not only to stay in their homes, but not to alter them in any way."

Some individuals adopt a kind of control center, Lawton says, in which they position themselves in a comfortable chair by the front door. They place themselves in view of a window and the TV and stack books, snacks, magazines, cards, knitting, etc. on tables

beside them. "They are willing to make these behavior adjustments to maintain control in their lives," he explains.

Almost twice the number of elderly could make some home improvements to increase their independence, says Windley, but they're reluctant to do so. "A phenomenon worth noting is the adaptive behavior of the elderly. They would rather limit their own behavior, which they don't view as a lack of independence, than to acknowledge a declining or inadequate residence — which is to acknowledge their own decline."

Windley relates the case of an elderly woman who lives alone on a house on a hill. Because of the steep steps leading to her front door, the woman only goes outdoors once a day, he says. For the same reason, her friends rarely visit her.

Windley and his colleagues tried to convince the woman to enter her home through her ground-level garage, in which the steps leading upstairs were more manageable, he says. But she refused. "That's no way to enter a house — through a garage," she said.

The point is that the elderly also have to become more flexible in order to increase their autonomy, just as society's image of the elderly has to expand.

Frequently the elderly's caregivers are the ones who inquire about home modifications, such as installing handrails and grab bars.

The elderly are reluctant to accept these changes, unless it's their idea — if they read about home improvements or hear about them through the grapevine, Windley continues.

However, they will allow these home alterations if it means they can avoid institutionalization. The bottom line is that many are willing to do things in order to add five to 10 more years of independent living, he says.

"The fact that the elderly may

“The (Baby Boomers) are hitting 40, and they are redefining the way we age in America. They are not going to grow old the way their parents did.”

be willing to make adjustments if *they* think of them underscores the need of the elderly to be in control of their lives,” he says. But they must educate themselves in order to exercise their options.

Still, some individuals do take advantage of their options and make modifications that range from the practical to the ingenious — using touch-sensitive lights, contrast tape on stairs, building ramps, modifying steps and using a sponge mop to clean high windows, to name a few.

At the same time, society has to get on the bandwagon.

“Sometimes technology is thoughtlessly applied,” says Windley. He points to things such as awkwardly placed grab bars, small doorways that deny access to wheelchairs and overhead ovens.

“We have to recognize the poor design of so much in existence,” agrees Mark Zitter, Director of Information Resources for Ageway, Inc., a communications marketing firm.

But there are some indications that society is beginning to turn around. For example, Sears now offers a line of clothes with Velcro, and products such as garden stools, emergency number systems and lift chairs are now available, Zitter points out.

But this attitude has to include basic structural changes in the architecture of society, by making restaurants, hotels, theaters and homes more age-friendly.

According to Leon A. Pastalan, the Director of the National Center on Housing and Living Arrangements for Older

Americans, one way to learn to better accommodate the needs of the elderly is to see the world through their eyes.

Pastalan presented two sets of slides at the conference depicting different locations: one through the eyes of someone with normal vision, and the second slide through the eyes of someone with cataracts.

“The purpose is to provide a tool to assess the physical environment and develop some kind of interventional solution,” explains Pastalan.

In a slide of a nursing home, Pastalan points out that the high-gloss walls and waxed floors aren’t particularly disconcerting for someone with normal vision. But for the person with cataracts, the scene appears to be drenched in fog and shadow, with doorways disappearing and poor visibility.

Pastalan ticked off a number of areas that future architects and designers can explore: wall and lighting improvements; eliminating shadow; and choosing carpeting or vinyl rather than tile.

Zitter believes that age-conscious products, services and environments will become more plentiful as the Baby Boomer generation moves into their middle and older years.

That’s because this group of individuals born between 1946 and 1964 have and will continue to have an enormous amount of clout in the consumer market. Not surprising really, considering the Baby Boomers comprise one-third of the population mass in the U.S.

As the Baby Boomers age, Zitter

predicts, there will be an *Age Wave*, which will “start small, gain power like a wave and then crest, affecting everything it comes in contact with.”

In other words, the *Age Wave* — the coming of the “mature” age of the Baby Boomers — will lead to a new image and society of aging. An elderly society that demands more and compromises less. One that demands its independence. One that is more responsive to alterations in the home — in fact, the elderly will not only accept these modifications, but will search for new ones to make living easier. In general, the *Age Wave* will have a more age-friendly personality.

“The Baby Boomers rewrote the entire mythology of America to fit their needs,” Zitter explains. “Now they’re hitting 40, and they are redefining the way we age in America. They are not going to grow old the way their parents did.”

He points to an ever-present trend in advertising to defy aging: “You’re not getting older; you’re getting better.” “I don’t intend to grow old gracefully. I intend to fight it every step of the way.”

“Everything about America is being changed by what was initially a demographic situation, that also became a social and cultural phenomenon,” he says.

For example, in the heyday of the Baby Boom years, the nation had baby fever; babies were a national obsession. As the Boomers aged, the nation’s preoccupations grew up as well —

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“We no longer think about age chronologically as much as how we feel, look, think and act.”

on to education and pre-teen concerns. Shows such as “Leave it to Beaver” and “The Little Rascals” captured America’s attention.

And then came the rebellious years. “Kids were always rebellious,” Zitter says, “but this was different. This was 76 million kids rebelling at the same time.”

Then the Boomers grew up and produced another national phenomenon: the Yuppie. The Boomers cut their hair, got jobs, and tried to ascend the corporate ladder.

Now, Zitter continues, as the Boomers creep into old age, the nation will again follow their lead. In fact, in some ways, this trend has already begun, he says.

“We no longer think about age chronologically, as much as we do in terms of how we feel, look, think and act,” he says. This is a society caught up in exercise, wellness, aerobics, cholesterol, facial creams, plastic surgery, hair tonics, and so on.

“The Boomers love youth so much they’re going to take it into their old age,” Zitter says. So what has been expected to be the “Graying of America” may turn out to be the “Tinting of America,” he jokes.

Which isn’t all bad. After all, this means that beauty will finally be weaned away from youth, which has already happened in a few cases, allowing Joan Collins at age 55 and John Forsythe at 70 to be believable sex symbols.

The concept that aging and sexuality are incompatible may also be reworked, Zitter suggests.

He says the aging consumer may begin to show more dissatisfaction with those hypertension medications that cause impotency, for example.

And perhaps the future may expand its collection of aging heroes — standouts such as George Burns, Lena Horne, Jack LaLanne, and even Ronald Reagan — as more and more Baby Boomers begin embracing this part of their life as if they were entering another prime.

As one actress recently responded when told she looked great for age 50: “You don’t understand: This is what 50 looks like now.”

Still, aging does have its unique palette of needs and demands that require special attention. But perhaps the *Age Wave* will create new opportunities and options and offer the elderly a bigger share of independence.

As Zitter theorizes: “It’s not unlikely that you can age well, but you have to work at it.”

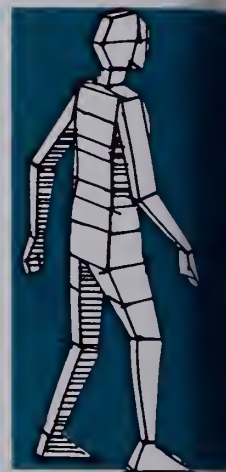
Deborah Athy is Associate Editor of **OHIO Medicine**.

Quotes of Note

“If physicians take more time with the patients there must be some way to reward them for providing better care . . .”

— **Michael Stocker, MD**
AMA News

Technology: The Elderly's Fountain of Youth?



By Michelle J. Carlson

There was a time, not so long ago, when growing old was considered a matter of course — a natural progression, if you will, that followed birth and preceded death. Stiffening joints, graying hair and failing eyesight, while certainly not welcomed, were simply accepted as signs of old age.

But in an era where medical miracles, cures and vaccines seem to be discovered almost daily, some in the medical field are beginning to question the notion that everyone must eventually grow old, frail and weak. With all the modern technology now available, they ask, is there not *something* we can do to slow the aging process? Something we can do to prevent wrinkles, arthritis, memory loss and the myriad of other health problems that typically plague the elderly?

Well, yes and no, according to speakers at a recent conference held at the Ohio State University entitled "Technology and Aging." There *is* technology available that can be applied to elderly patients, they say, but instead of focusing all of our resources on the aging

process and life extension, why not concentrate efforts on preventing and postponing disease, improving the quality of life at hand?

"There are people who, for a fee, will freeze your body and thaw you out once a cure for your disease is found," notes James Fries, MD, an associate professor at Stanford University's School of Medicine, and the opening speaker at the conference. "It's amazing all the ideas and notions people come up with . . . Unfortunately, technology hasn't contributed much to life extension in the past and it's unlikely to contribute much to life extension in the future."

The reason, he says simply, is because the human life span is essentially fixed. "Life expectancy is at a plateau right now," says Dr. Fries.

What the medical community should do, he continues, is encourage patients to take responsibility for their lifestyles, encourage them to change what he refers to as "modifiable aspects of aging."

"The parts of aging that are important are the modifiable

aspects," he says, "because these give you quality of life."

If, for example, patients can be convinced early on to carefully monitor their blood pressure and serum cholesterol and to exercise regularly (thereby increasing their cardiac reserve), chances are they'll avoid, or at least postpone, certain diseases later in life.

"If we're interested in compressing morbidity," Dr. Fries explains, "we have to think about postponing disease. It was and is very easy to change morbidity through intervention."

On the other hand, he reminds us, "It's very hard to change mortality."

The "chronicity crisis"

No discussion about the elderly would be complete, of course, without mentioning the *nature* of their diseases. In fact, according to Eldonna Shields-Kyle, RN, a gerontological nurse specialist at Nord Community Mental Health Center in Lorain, this aspect of gerontology has changed immensely in recent years, largely because of advances made in medicine.



With the development of antibiotics and vaccines, for example, many diseases that previously threatened the elderly have since become manageable. Consequently, today's elderly not only live longer, they suffer primarily from prolonged, *chronic* illness.

"Chronicity has never been a big issue in the past because we didn't live long enough to develop chronic disease," says Shields-Kyle. "Back then, they worried about acuity . . . but today, chronicity is a major problem."

Chronic ailments such as arthritis, for instance, can severely limit the number of things an elderly patient can do, says Shields-Kyle, noting that typical complaints include difficulty fastening buttons and snaps; difficulty cleaning, vacuuming and dusting; and difficulty using the bathroom and shower.

Health-care workers, as well as family and friends, must be aware of the elderly's special needs, she says. "When we expect the older adult to take a bath in 15 minutes, we're asking the impossible . . . we have to remember that

neurologically, we slow down when we get older. It takes longer for messages to travel from our brain."

In dealing with elderly patients, Shields-Kyle encourages health-care workers to downplay the fact that the patient is chronically ill. "We need to begin looking at the health of people and describing it, rather than talking about what's wrong with them," she says. "Even the dying person has health — if we look for it. I think we can describe these people just as accurately if we talk about what's right with them."

Shields-Kyle also reminds the profession that the fine line between health and disease is often difficult to distinguish. "We have health at one end of the continuum and disease at the other, but I think it's more complex than that," she says. "Is birth the ultimate health, and death the ultimate disease? Because I think death is healthy. You know, no one is getting out of this alive."

The elderly explosion

If chronic disease among the

elderly is considered the latest crisis in health care now, just wait 10 or 20 years, says Robert Atchley, PhD, director of the Scripps Foundation Gerontology Center at Miami University, Oxford.

"There's a lot of controversy over what's going to happen to life expectancy, but no one really knows," he begins. "What I can say is that there are more people now over 95 than ever before . . . but if you think we've encountered a lot of older people in our population thus far, just wait. The Baby Boomers are getting older every day."

And, as the Baby Boomers grow older and swell the ranks of the elderly, the U.S. is going to find itself in serious economic trouble — unless the problem is addressed in advance.

"There's every indication that it's going to increase dramatically," says Atchley. "It's the 85 and overs who are going to be filling up at the turn of the century. That has a lot of implications when it comes to the need for technological compensation."

Continued on page 453

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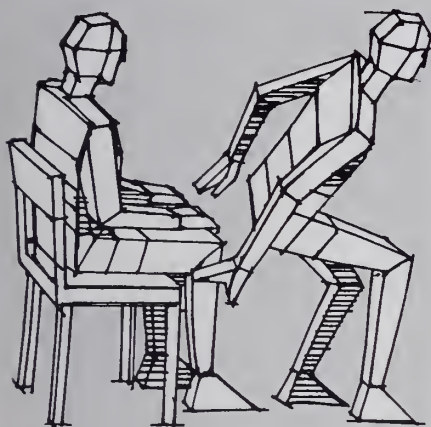
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Instead of focusing all of our resources on the aging process and life extension, why not concentrate on improving the quality of life at hand?

As if to make matters worse, this so-called "Graying of America" isn't limited to the U.S. at all, says Atchley, who predicts the "elderly explosion" will become a worldwide phenomenon. A case in point, he says, is Japan, where poverty among the elderly is becoming the rule, rather than the exception. And if a developed, industrialized nation like Japan is already having problems coping, one can only imagine what will happen when other countries start experiencing similar crises.

The economics of aging

Returning to the problems at home, at least one conference speaker believes we must begin addressing the problem of how this country plans to support its elderly in coming years *now*.

"We have to save some of the social engineering that has been established," says James Schulz, PhD, of the Heller School at Brandeis University, "and I'm talking about Social Security."

Schulz, who fears cutbacks in the system are imminent, says that three issues have dominated discussions about economics and the elderly of late: (1) Federal deficits may require a change in the Social Security System, (2) the rapid aging of the U.S. may require an extension of the Social Security age for retirement, and (3) new realities of aging may mean moving away from Social Security as a prime support of the elderly.

However, says Schulz, "In my opinion, none of these deserve support . . . the elderly have become a sacred cow. You can't separate the economics of aging from the politics of aging."

One reason cuts in Social Security have been supported by some, he says, is because of the current surplus of funds in the

system. But the situation is only temporary: Millions of Baby Boomers may be pouring huge amounts of money into the system now, Schulz notes, but a deficit will almost certainly arise by the time this same group reaches retirement age, mainly because the younger generation paying into the system will be so much smaller in size.

"If we want to cut back on these programs," Schulz says, "we have to ask who will take responsibility. Businesses? Families?"

Social Security, he argues, has been the backbone of the welfare state for good reason: Only the government can secure such a large number of benefits; it's efficient to build up a large pot of money; and parents and children alike support the system and the dignity it affords as a prime means of support of the elderly.

To make cuts in the program, Schulz maintains, is to slit the throats of the elderly. "It's no mystery what's going on: Slow economic growth and military spending have put huge strains on the government." But, he adds, "We shouldn't kid ourselves that the answer is privatization and decentralization."

What is the answer then? To become educated and informed about the problems the elderly face and to beware of any proposals that would drastically change the existing system, Schulz says.

"Be skeptical when the next huckster comes your way with a better way to build a mousetrap," he warns. "It may be you, not the mouse, who gets caught." **OSMA**

Michelle J. Carlson is Editorial Assistant for OHIO Medicine.



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Lifeline and SMART HOUSE: Technology Comes Home

By William J. Pomidor, MD

Seventy-two-year-old Eunice Lockhart lives alone. After her husband died last year, her three children invited her to live with them, or in an apartment. But she cannot bring herself to give up the home where she spent the last 40 years of her life.

Even Eunice was worried though, when she came home from her total hip replacement, just after Christmas. For although her mentation is intact, her mobility is not. She can move about on the first story of her home, but only with difficulty.

One morning, as Eunice is in the kitchen making coffee, she blacks out and falls to the hard linoleum floor. Waking up seconds later, she struggles to return to her feet, but the pain in her leg is so intense she fears she may have broken it.

The telephone is in the next room, only 20 feet away, but to Eunice it might as well be 20 miles.

Despite the pain, Eunice remembers the device she wears around her neck. She presses a button, and the Lifeline unit in her home sends a distress signal to

the staff at the Lifeline center. Within minutes, she is on her way to the hospital.

Twenty years ago, the above episode might have seemed like science fiction. The example is indeed fictitious, but there are hundreds of people like Eunice in every major city. Without a Lifeline unit or similar device, such people might have to wait hours, even days, for help to arrive. If those people are diabetic or cardiac patients, the hazard of waiting is multiplied even further.

Lifeline, and programs like it, enable people like Eunice Lockhart

to call for help without reaching a telephone.

"Lifeline is a personal emergency response system," says Larry Brown, program manager for Lifeline in Summit County. "It allows people (who might otherwise have been institutionalized) to live at home independently. These are people who have some medical problems but can live at home, usually alone, with some supporting system."

Designed by Andrew Dibner, MD, Lifeline's communication network is surprisingly simple. An elderly, chronically ill or homebound person using the program wears a personal transmitter around the neck. The transmitters are small, about the size of a box of safety matches.

In case of an emergency, the participant presses the button on the transmitter. A home communicator, tied into the home's telephone line, receives the signal and transmits a call for help to the area's Lifeline center. On receiving the call, the Lifeline responders execute a prearranged response plan.

"We first try to call the person," says Brown. Most of the calls received are false alarms, but if the user fails to answer, "We try to call the people they have designated as responders. Failing any of that, we call EMS."

Even in the case of prolonged unconsciousness due to a fall or other mishap, help can be obtained. The Lifeline unit has an inactivity monitor with a timer. If the user is inactive over a designated period of time, a signal is automatically sent to the Lifeline center.

If a person lacks friends or family to serve as volunteer responders, there are other options. "We don't have a real problem with that," Brown notes.

Continued on page 458

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Clearinghouse Established for Technology and Aging

With the rapid growth of the elderly population in America has come heightened interest in the field of geriatrics. Concomitantly, a new type of technology is expanding: one which focuses on the elderly, aimed at improving the quality as well as quantity of life available to them.

But navigating through the rivers and streams of new information is often bewildering for the average clinician. It is difficult or impossible to remain current on the latest technologies and devices which might improve the lives of geriatric patients who are hearing impaired, visually impaired, or have other special needs.

The National Clearinghouse on Technology and Aging was established to foster awareness of the products and programs available to serve the elderly. "The National Clearinghouse is the only one of its kind," says Gari Lesnoff-Caravaglia, executive director of the University of Massachusetts' Center on Aging. "Members of the clearinghouse gain access to a large database on the various technologies available to the elderly and sensory impaired. Additionally, members can receive information on funding sources for the special programs." And by joining the clearinghouse network, participants gain easier access to the experts in a particular field.

By paying an annual membership fee of \$50, researchers, clinicians and the lay public may become part of the network. Members of the clearinghouse receive subscriptions

to the biannual *Bulletin*, which lists the latest resources acquired by the clearinghouse, as well as technical information and notices. Additionally, a 20 percent discount is applied should members wish to subscribe to the *International Journal of Technology and Aging*.

But one of the most important aspects of membership in the clearinghouse is free access to the Sensory Technology Information Service (S.T.I.S.). This computerized system provides information on assistant technology and services for persons of all ages with sensory disability (hearing and visual). Typical entries include a voice-activated telephone dialer, paper money identifier and auditory mobility aid for the blind.

Information on the various products includes cost, availability, manufacturer and description, as well as any special training required. Additional resources of S.T.I.S. are consultants, literature, vendor contacts and information on other databases. S.T.I.S. is also available at no charge to the disabled (they need not be members of the clearinghouse), and reports can be specially prepared to meet the needs of those persons. — *William J. Pomidor, MD*

For further information on the clearinghouse, write:

National Clearinghouse on
Technology and Aging
University Center on Aging
University of Massachusetts
Medical Center
55 Lake Avenue North
Worcester, MA 01655

"Generally they can find someone — neighbors or friends. In some cases, we've found another Lifeline person in the same building who agrees to be a responder."

In extreme cases, Emergency Medical Service itself may act as the responder. Naturally this is discouraged in order to avoid false alarms.

Summit County's Lifeline system helps about 500 elderly or homebound persons, but similar systems are available across the country. "There are over 1,200 programs nationwide," says Brown. "The Cleveland area alone has eight or 10 programs. Typically they are part of a large hospital or social service agency."

Physicians interested in referring patients to the program should check with their hospital or local information referral service.

By allowing the elderly or homebound to live independently in safety and security, Lifeline represents an important new direction in medical technology. But for those who look to the future, Lifeline itself represents only the tip of the iceberg.

With the introduction of the microchip has come a wave of progress in the development of devices to aid the aged, disabled and sensory impaired. In order to facilitate the exchange of information on the new devices and technologies, a National Clearinghouse on Technology and Aging has been established (see sidebar).

One way to integrate the new instruments into a cohesive unit is the so-called SMART HOUSE.® In November 1987, the SMART HOUSE Development Venture displayed its plans to the Gerontological Society of America at its annual conference in Washington.

"SMART HOUSE is not being designed specifically for the elderly or handicapped," warns Brian

Boscolo, the SMART HOUSE representative who coordinated the November exhibit. "But at the same time, there are applications which would make living for the elderly or handicapped much simpler in the SMART HOUSE."

The basis for SMART HOUSE is the combination of an advanced wiring and piping system with a computerized monitoring ability (the "brain" which makes the house intelligent). The new design features hybrid cables offering electric power, communications, entertainment, security and safety functions throughout the home. Natural gas is distributed through a semirigid piping system.

The idea seems rather simple, but the potential advantages of such a system are just being realized. The "closed loop control" system combines the unique wiring scheme with computerization, enabling individual monitoring of appliances. In case of malfunction, delivery of electricity is halted at the outlet. Thus power is delivered for a properly running appliance, but the same outlet would deliver no electricity in the case of a short circuit, or if a screwdriver or knife were introduced to the socket.

Similar monitoring systems will be applied to gas and water lines, so that if a possible leak is detected, the owner will be informed.

Other applications include medical monitoring systems similar to Lifeline, but activated by voice rather than a portable transceiver. And appliances could be "locked" so that the dangers of stoves or electrical appliances for demented or learning disabled clients (as well as children) would be minimized.

For the deaf or hearing impaired, messages concerning home security, malfunctions, or simply timers for oven and microwave, could be flashed on the

Continued on page 461

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Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions, General:—1 Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2 Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3 Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests:—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions:—No interactions have been observed between Axid and theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility:—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 350 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C:—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers:—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use:—Safety and effectiveness in children have not been established. Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to

determine whether these were caused by nizatidine.

Hepatic:—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase) occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular:—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine:—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic:—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumentary:—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other:—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Axid[®] (nizatidine, Lilly)



Eli Lilly and Company
Indianapolis, Indiana
46285

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television screen. A blind person who was unaware that the home's security lighting had burned out might be given such information through a braille-encoded control panel or synthetic voice communication.

And most of the technology to perform these services is here today. SMART HOUSE only facilitates use of the new devices by integrating them within the home. "The real benefits come in the convenience and control that such a system offers," Boscolo adds. Innovations which might otherwise be incompatible or confusing to the user can be harmonized, their function simplified and centralized.

For a typical home, Boscolo estimates that the new system would cost approximately \$7,000 to \$10,000 more than the cost of building a conventional home. Unfortunately, most elderly persons lack the finances to purchase a new home and equip it with "smart" technology, but in the future, such systems may become more available.

"One of the discussions we had when talking with the Gerontological Society was whether this type of system would be accessible for multi-family dwellings and apartments," Boscolo recalls. "I think that down the road we would be available for retirement communities . . . That's not what we're initially gearing up for. But I think the transition from new homes to new multi (family) dwellings would be a simple one to accomplish."

The significance of such developments as Lifeline, home automation and other technologies for home use by the elderly and disabled cannot be overemphasized. No price can be placed on the lives that such systems might save, nor can a

Continued on page 462

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monetary value be calculated for the convenience and independence which such persons would become able to enjoy. The cost of living in nursing homes and assisted care facilities is known, and the price is quite high, but when the cost-benefit ratio of the new technologies is placed in perspective beside the alternative modes of care, such advancements may become even more appealing.

In the clinic and hospital, technology has helped modern medicine to increase the span of our years. Now in the home, that same technology holds the promise of enhancing the quality of those newly acquired years. **OSMA**

William J. Pomidor, MD, contributes frequently to OHIO Medicine. He writes from Stow, Ohio.

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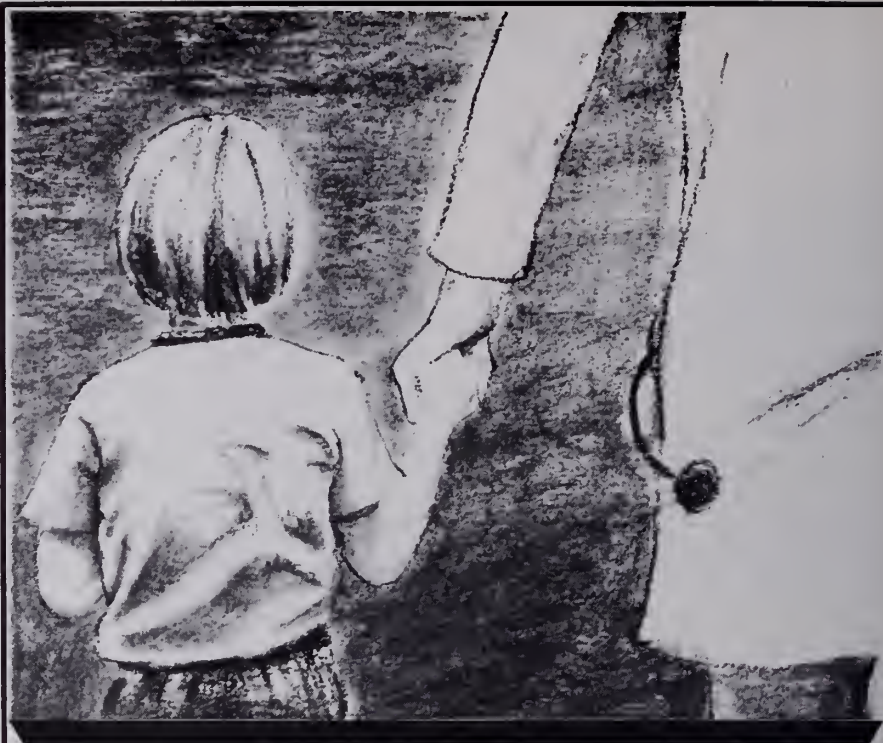
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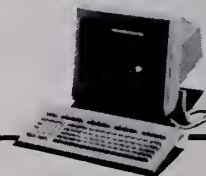
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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acciardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980; 4(6): 392-397. 3. Skoutakis VA, Carter CA, Acciardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987; 21: 436-440.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving diuretics and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets. To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq of 10% dextrose solution containing 10-20 units of insulin per 1,000 mL; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K).

Bottles of 100 NDC 0083-0165-30

Bottles of 1000 NDC 0083-0165-40

Consumer Pack—One Unit

12 Bottles—100 tablets each NDC 0083-0165-65

Accu-Pak® Unit Dose (Blister pack)

Box of 100 (Strips of 10) NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

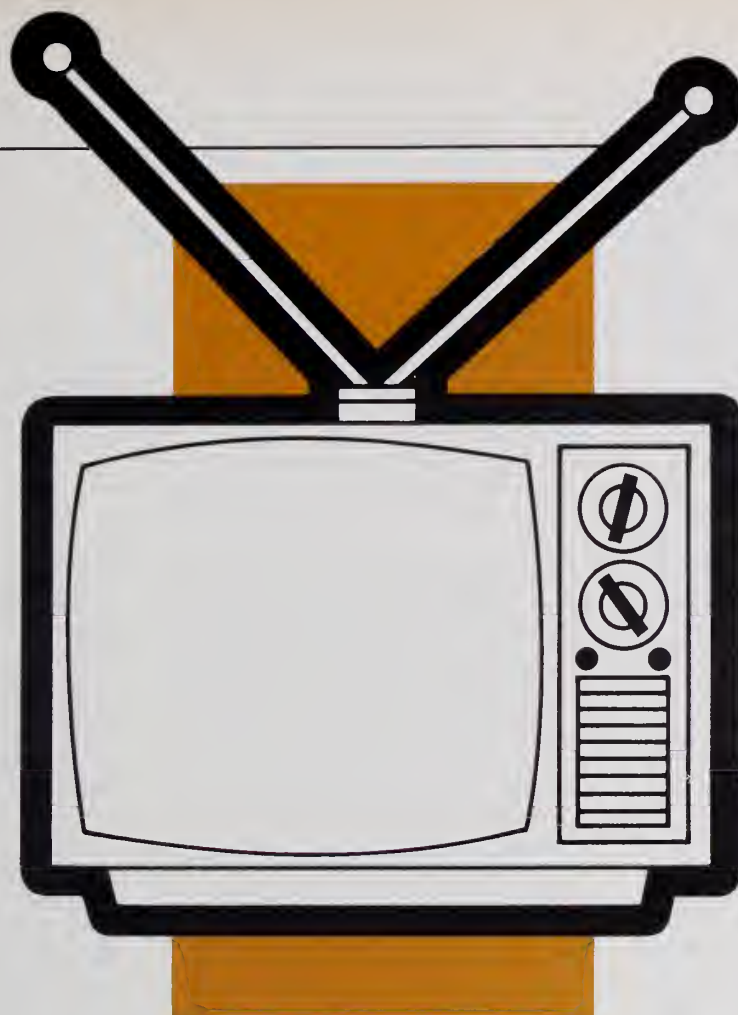
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Television Therapy

By Gregory G. Young, MD

The purpose of this article is primarily threefold: a) to outline an empirically derived psychodynamic theory of personality which delineates 12 distinct personality styles, b) to introduce a novel therapeutic approach, "Television Therapy," a device designed to promote greater self-awareness and self-under-

standing through the use of personality styles and how these personalities are shared by prominent television characters, and c) to provide several applied examples of Television Therapy while demonstrating the mechanics of this approach. The relative merits of Television Therapy are also discussed.

Historically audiotape, and more recently closed circuit video recordings, have been utilized as a therapeutic adjunct in a variety of treatment settings. These tools have served many purposes including performing a facilitative role in the group therapy process, making psychiatric consultation accessible to remote localities,

and providing an effective means of educating and training mental health professionals and patients alike, on any number of therapeutic issues. Utilization of audio and video technology has provided opportunities for increased self-awareness and self-understanding, particularly when applied to group and individual therapy, by

means of a highly objective and accurate depiction of interpersonal and individual dynamics. It was with these same goals in mind that I developed Television Therapy.

In over 20 years of psychiatric practice, I have met thousands of people from all walks of life. In speaking with these people in a variety of situations I began to

“My personality is just like Ralph Kramden on ‘The Honeymooners’ . . . I try so hard to please people.”

hear many similar expressions of attitudes, fears, wishes, and ways of dealing with life. I did not set out originally to match people to any sort of preconceived notion, but throughout the years, and all the communication, I could not help but notice that there seemed to be recurrent themes that emerged, themes that were peculiar to certain recognizable groups.

As time went on I began to document these similar attitudes and characteristics, not only those of my patients, but friends and acquaintances. I particularly focused on individual self-descriptions, allowing people to express their self-perceptions, personal strengths and weaknesses, problem-solving methods and means of communication. As I continued to investigate this apparent phenomenon I employed a variety of experimental methods to substantiate it including: case studies, questionnaires and countless hours of personal observation and clinical interviews. These efforts culminated in the development of an objective personality inventory consisting of: true and false, and forced-choice questions in addition to a section devoted to a written personality self-description. It is primarily through the use of this instrument (which I have called the YOU Inventory — the Young Opportunity to Understand), and my clinical observations that I determine an individual's personality style. Based on this research I concluded that there are 12 identifiable personality styles. Those 12 include: ambitious, perceptive, anticipating, conscientious, accomplishing, persistent, influencing, patient, idealistic, sensitive, determined and adaptable. (Please see the enclosed descriptive summaries of the 12 personality styles.) It should be noted that these descriptive titles were not selected randomly, but rather they were chosen based on subjects' self-descriptions.

My intention here is not to diminish the uniqueness of the individual, nor is it to minimize the importance of early life experiences, learning or environmental influences on personality development. My

objective is to propose a system of classification which highlights empirically derived similarities among human beings, a modern day discovery that will influence the way human beings live their lives and interact with each other.

Although each person creates his or her own life to a varying degree, each of us does it in a way that can be positively and accurately identified by one of these 12 personality styles, and in a way that is common to those who share that particular style. With the concept of personality styles firmly established I began to experience, through the interaction with my patients, a situation that caught me somewhat by surprise. On frequent occasions my patient would compare themselves to certain characters on television. One patient confided, “My personality is just like Ralph Kramden on ‘The Honeymooners.’ ” Another said, “My wife acts just like Miss Kitty on ‘Gunsmoke.’ ” My initial reaction was to politely dismiss these comparisons as insignificant. Despite my ambivalent reaction these comparisons persisted. As I continued to listen my skepticism gradually diminished and I recognized that the basis of these comparisons was anything but insignificant. For example, the individual who likened his personality to that of Ralph Kramden made this judgment based on the observations that, “I'm like Ralph in that I try so hard to please people, I like a challenge and when I fail I try even harder. It doesn't always work out like I want it, just like Ralph, but if it doesn't it isn't because I didn't give it my best shot.” In this case it was not that Ralph Kramden was an overweight, boisterous, argumentative bus driver that caught this man's attention, it was the much more subtle, underlying needs and motivations of this TV character with which my patient had identified.

Because of this and similar experiences my curiosity was piqued regarding who these characters were and why my patients and their families had identified so closely with them. As I thought and watched, the answers became obvious: Television was

simply a matter of art (or entertainment) imitating life. My patients were actually sharing personality styles with their “Television Twins.” I coined this term to identify my newly-formed concept which states that we share similar characteristics, needs, desires and means of interacting and communicating with characters on television and thus we can learn and benefit from them, albeit vicariously.

With that in mind, I began studying a number of TV stars and the characters they portrayed. I determined the personality styles of the stars by analyzing and reviewing television interviews, magazine and newspaper articles, and books, by making personal contacts and by administering the YOU Personality Inventory to a variety of individuals. This extensive investigation, which is an ongoing process, yielded three very interesting propositions. First, most of the shows that stay on the air for any length of time do so because the character's parts and dialogue are consistently written in a way that matches and enhances that character's personality style. Of course the writers, producers and directors of these shows are not consciously utilizing any direct knowledge of personality styles, but most of them are students of human nature, and they have simply found a formula for success. Second, the manner in which a particular character meets and deals with situations often parallels the experiences of my patients who shared that character's personality style. Finally, in my estimation, most of the successful TV stars portray characters who share their own personality style.

At that point, the next logical step was to catalogue television characters until I had enough to represent each of the 12 personality styles. With the advent of video recorders it became possible to study both programs and characters more closely and to preserve certain episodes that offer exceptionally accurate or interesting portrayals of a particular personality style. Then, when patients came to me with problems or difficulties I could prescribe that they watch the characters who

share their personality style, thus enabling them to work through some of their problems vicariously and possibly apply what they had viewed to their own personal situations.

Discussion

Throughout history, people have looked to literature in an attempt to discover models of human behavior. In enduring literary characters we find personality traits we can relate to and learn from. The classic works of Homer have served as a tremendous source of inspiration for thousands of years, while the parables of the Bible provide essential insights into the human condition. More recently the writings of Shakespeare, Dickens and others, and the characters they have so eloquently described, e.g., the ponderous, meditative nature of Hamlet, the youthful exuberance and innocence of Romeo and Juliet, and the resourcefulness of Oliver Twist, allow us an opportunity to examine and benefit from the experiences and motivations of these fictional characters and thus, gain greater insight into our personal situations.

Mahoney (1965) has made extensive use of literature when teaching psychotherapy to clinical psychologists. As a result of his experience he has become "convinced that fiction has an important place in the clinical training program." The value of fiction lies in the fact that it is designed to evoke feelings. The reader comes to an understanding, not only of others, but also of himself if he is alerted to his own feelings and reactions as he reads.

In a similar vein, Sigmund Freud utilized characters from Greek mythology as explanatory concepts regarding his views on the development of personality. More recently Maslow has described several prominent historical figures, such as: Abraham Lincoln, Eleanor Roosevelt and Martin Luther King, as having achieved a state of self-actualization, the pinnacle of individual potentiality. Acquiring an understanding regarding the manner in which these individuals and others like them, conducted their lives, resolved problem situations and overcame tremendous obstacles, each in their own distinctive manner, provides us with invaluable insight which can aid us as we attempt to become all that we are capable of. In addition, the widely regarded Social Learning Theory of Albert Bandura stresses the

paramount importance of modeling, regarding our behavior and how we are influenced by those around us.

In my own practice I have often recommended that patients read works by such authors as Dostoevski and Dickens in an effort to help resolve emotional or psychological problems. In general, however, the compliance rate of these patients has not been good. Because of this I felt I needed a more accessible means for people to examine personal issues outside of the traditional therapeutic relationship. With this thought in mind I began to lay the ground work for just such an alternative, Television Therapy.

As with the previously mentioned methods of therapy, Television Therapy provides an opportunity for increased, albeit vicarious, self-awareness and self-understanding, but with some added dimensions.

Nielsen media research estimates that 87.4 million U.S. households owned at least one TV set as of January 1987, a figure which represents approximately 98% of the total households in this country. Research further suggests that TV households viewed a record high average of seven hours and 10 minutes a day during the September 1985 to August 1986 TV season. Perhaps an even more startling statistic is the fact that the lowest viewing group surveyed, single person households, had their sets on over 41 hours a week, more time than most people spend at their jobs. Also, by the age of 18 the average high school graduate has viewed in excess of 15,000 hours of television.

What these statistics seem to suggest is that we have become a society whose primary influence is the medium of television. In the next half century this trend is not only likely to continue, it is quite probable that the significance and impact of television on our every day lives will increase to even greater proportions. With this in mind I feel we have but one viable and realistic option, to develop new methods by which we can better utilize and learn from television.

Before presenting a few clinical examples of how I utilize Television Therapy I feel it is necessary to clarify several points regarding this novel therapeutic approach. Initially, I am not advocating that individuals become slaves to their TV sets, spending every free moment fixated on the tube. Nor do I believe that viewing tele-



vision should serve as a substitute for direct communication between family members and friends. On the contrary, tuning in to one's "TV Twin" can facilitate healthy discussion among family members.

Another issue I would like to address is the fact that television therapy is not appropriate for everyone. Obviously patients experiencing problems of an organic nature or those with acutely psychotic disorders, whose grasp on reality is often tenuous, would not benefit and in fact could be irreparably harmed by such an approach. Likewise, patients who are in the midst of a severely anxious or depressed state would require some stabilization before considering Television Therapy. Those who appear to benefit most from this method of treatment are individuals who are intact psychologically, but may be dealing with any number of emotional or situational difficulties, or who are simply trying to increase their self-awareness and personal development.

An additional point which deserves some clarification is the issue of process versus content with regards to the use of Television Therapy. Most of what comes into our homes on the tube is certainly tastefully exaggerated. It is unlikely that many of us would be confronted with problems such as trying to maintain an extensive oil empire, like J.R. on "Dallas." It is equally improbable that we would experience the tremendous anxiety associated with tracking down desperate criminals like Chris and Mary Beth on "Cagney and Lacey." While we may have difficulty relating to, understanding, or even believing the situations we witness on television, I am convinced that we can learn and benefit from *how* these problems are resolved. The pain of divorce or anxiety

At this juncture, I began to catalogue television characters until I had enough to represent each of the 12 personality styles.

over a wayward child are felt equally on both sides of the screen. On the occasions I use Television Therapy I instruct my patients to focus on the process involved in the problem resolution rather than highlighting the context of the situation in question. Because of this, more active participation is required from the patient for this procedure to be successful. It has been my experience that this active involvement correlates in a positive fashion with a patient's retention and future use of the insights gained from this exercise.

Finally, the underlying assumption of Television Therapy is that people can learn vicariously from characters on television who share similar traits and tendencies with them. We can learn more positive ways of communicating with those around us and avoid those methods of interacting that are unsuccessful. Thus, Television Therapy provides a double benefit. In my view it is an extremely accessible and entertaining approach whose time has come. In the following section I would like to present several examples of Television Therapy at work.

A particular patient of mine who has an Accomplishing Personality Style was having severe interpersonal problems with his family. His wife and children, not realizing that an abundance of energy and enthusiasm are characteristic of the Accomplishing Style, were constantly imploring him to "slow down," and "to take life a little easier." His wife, in addition to advising him to slow down, was also critical of his behavior at parties and social events, accusing him of being a "ham" and of constantly needing to be the center of attention.

All of his efforts to slow the pace of his activities and to stay in the background at social gatherings were having an adverse effect on him and he consequently became increasingly depressed.

My therapeutic intervention was to have him watching Accomplishing characters on TV, typically at least three, to note their extraordinary energy and enthusiasm, and how the approval of the audience or the

people around them was exactly what they needed. That experience helped to reassure him that his behavior was quite appropriate for his personality style.

I encouraged his wife to accompany him on his next session and together we watched a segment of "Who's The Boss," which showed the lead character Tony, an Accomplishing Personality, seeking approval with attempts to entertain in a social setting. When Tony's behavior was approved of and encouraged, he was happy and content. When disapproval was the response Tony was distressed and devastated.

In this case my Accomplishing patient was able to discover, through viewing TV characters who shared his personality style, that "slowing down" was bad advice for him. His wife gained a new understanding of his need to entertain at parties and began to better appreciate his ability to know and to be himself, albeit a "ham."

In another case a patient with a Perceptive Personality was demonstrating what I determined to be a generalized anxiety disorder. The etiology of this disorder appeared to be due, in part, to the criticism she received from her friends and family for being "too emotional." Her husband was also constantly accusing her of "spreading herself too thin" in that she would sacrifice her time and energy to help people she perceived to be in need instead of devoting that time and energy to the immediate family.

Watching a variety of Perceptive characters in various television segments enabled her to realize and accept the fact that overt and intense emotional responses are simply a characteristic of the Perceptive Personality. She watched the Perceptive character Mary Beth Lacey from the series "Cagney and Lacey" and observed Mary Beth's emotional response to her son's mugging, alternately scolding and expressing loving concern. I had her and her husband view an episode of the show "227" where the Perceptive character Mary is immediately prompted into preparing a large

pot of stew for the destitute people she had discovered were staying in the apartment upstairs.

Through viewing characters on TV who shared her Perceptive Personality, in addition to my prescription for small doses of anti-anxiety medication, this patient was able to reconcile herself and her husband to the fact that her Good Samaritan tendencies were only normal and natural for her. She also discovered that she was not the "emotional wreck" she had been accused of being; that feeling sadness, joy, love, concern, and anger more intensely than others around her was simply recognizing and accepting her Perceptive Personality.

Summary

Within this article I have described the evolution of an empirically based theory of personality, delineating 12 distinct personality styles. Each of these 12 includes characteristics, for example, personal strengths and weaknesses, problem-solving methods, and means of communication, that are peculiar to a particular personality style. I determine an individual's style based on the results of an objective personality inventory I have developed, personal interviews and my own clinical observations.

Early in my professional career I noticed that many of my patients, as well as friends and family, would frequently compare themselves and others to certain characters on television. Initially, I dismissed these comparisons as being insignificant, but despite my ambivalent reaction these comparisons persisted. As I continued to investigate this phenomenon I came to the conclusion that these individuals were actually sharing personality styles with these characters on television. Given a certain situation John Doe would and did respond much in the same way as Ralph Kramden, and so Television Therapy was born.

At this juncture I began to catalogue television characters until I had enough

Continued on page 470

**THE POWER TO PREVENT
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ZERO-ORDER ORAL THEOPHYLLINE
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THEO-DUR[®]
(theophylline anhydrous) Sustained
Action
Tablets

**There's no substitute
for success.**

Please see following page for brief summary of prescribing information.

THEO-DUR®

THEOPHYLLINE (Anhydrous)

Sustained Action Tablets

INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both additional medication, parenterally administered, and close monitoring, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e., nausea and restlessness) may occur frequently when initiating therapy, but are usually transient, when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions, or even death may appear as the first sign of toxicity without any previous warning. Stated differently, serious toxicity is not reliably preceded by less severe side effects.

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (mice, monkeys, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with ephedrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether the bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets. The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered

1. Every 24 hours in children under 12 years of age, have not been established.
2. Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are

1. Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea
2. Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias
4. Respiratory: tachypnea
5. Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.
6. Other: rash, hyperglycemia and inappropriate ADH syndrome

OVERDOSSAGE Management: If potential oral overdose is established and seizure has not occurred

- A. Induce vomiting
 - B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken)
 - C. Administer activated charcoal
- If patient is having a seizure
- A. Establish an airway
 - B. Administer oxygen
 - C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg
 - D. Monitor vital signs, maintain blood pressure and provide adequate hydration

Post Seizure Care:

- A. Maintain airway and oxygenation.
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis, however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

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Television Therapy . . .

continued

to represent each of the 12 personality styles. When patients came to me with particular problems I could prescribe that they watch these characters who share their personality style, thus enabling them to work through some of their problems vicariously, learning both positive and negative alternatives, while increasing their self-understanding.

When utilizing this novel technique, however, my focus is on the process, how a problem is resolved, rather than highlighting the context of the situation in question.

As demonstrated in the previous examples, Television Therapy allows us to explore our personal strengths, weaknesses, character traits and tendencies by means of a widely accessible and thoroughly entertaining medium. This technique further provides a degree of objectivity which obviously is of paramount importance in terms of increased self-understanding.

In recent years there has been a growing trend on television toward the investigation of common everyday problem situations. Issues such as death and grief, drug and alcohol abuse, single parenting, AIDS and birth control are being dealt with on a regular basis. This trend seems to enhance the potential significance of Television Therapy in the future.

The medium of television is and will continue to be the single most important source of information in our society. With my concept of Television Therapy, the TV simply becomes another option for understanding and feeling good about ourselves. So stay tuned. Your time spent in front of the television can be more valuable than you have ever imagined.

Personality Guide

1. Persistent: Believable, soft, gentle, searching, persuasive, strong emphasis on hope and faith, often makes a believer out of others, charismatic, does best in a one-to-one relationship, and is persistent in building these relationships, dreams are important, creative thinker, late bloomer.

2. Idealistic: Interested in image, independent, self-sufficient, poised, cool, marches to own drummer, sticks to strong standards and ideals, has a tendency to back off when people get too personal, verbal and lively conversationalist, likes to debate on intellectual level, free-spirit, objective, uncomfortable with weaknesses.

3. Sensitive: Curious, very watchful, listens a lot, says a little, very aware, works

well alone, takes job very seriously and is very responsible, lives by the Golden Rule, sensitive to others and their needs, tends to dwell on their own vulnerabilities rather than strengths, strong family orientation and very loyal, shy with strangers, open with close friends, privacy is important, affected by your environment, nature lover.

4. Perceptive: Compassionate, much empathy for others, emotional, helpful, sympathizes with the underdog, needs to feel appreciated, can be jealous on occasion, animal lover, values honesty and fairness, protection of loved ones, outspoken especially when unfairly treated, romantic, the original Good Samaritan, wants and needs affection.

5. Adaptable: Your life is an "open book," flexible, able to fit into any situation, is aware of whatever is current, avid listener, good in public relations, verbal and lively conversationalist, can play the role of devil's advocate, can be competitive but rarely threatening, different friends for different occasions.

6. Influencing: Emphasizes neatness and cleanliness, impatient when things aren't perfect, well dressed, well organized, emphasizes control, good story teller, charming, often looked upon as a leader, time and schedules are important, very responsible, likes to go first class, strives for the grand and glorious in life — the ultimate, functions best when given choices.

7. Conscientious: Logical, concerned with facts and figures, tends to procrastinate, compiles large amounts of data and information before making decisions, tends to be a creature of habit, wry/sly/dry sense of humor, practical jokers — one liners, often doubts decisions, stores many facts, asks many questions.

8. Anticipating: Planner, always thinking of the future, genuine, authentic, hates being phony, wants to feel that what they are doing is important, does not like change, tendency to worry, thorough, does better when busy, organized, dislikes being rushed, needs to feel a part of things, gradual approach.

9. Ambitious: Competitive, hard driving, talks about goals and winning, accepts challenges, works well where there are many opportunities to succeed, good at getting things done, action oriented, difficulty with enjoying successes, a "what's next" approach, works long hours, aggressive, likes to keep an eye on the competition.

10. Determined: Wants to be right and



WIDEWORLD PHOTOS

TV characters "Kate and Allie" are used frequently by Dr. Young to point out the persistent personality type (Kate) and the anticipating personality (Allie). "Kate feels comfortable with her wishes and creativity, and when someone on the show needs help, she can focus all of her attention on that one person. By doing so, she helps them to accept themselves. Allie is always worrying, but the good thing is, she worries out loud, indicating that it's OK to have apprehensions and to express them. That's the way we make plans," says Dr. Young.

respected, sees self as responsible, would rather be right than be popular, often indirect, does not like to argue or hassle, solves problems in a reasonable and strategic manner, will clam up under stress, often does not declare opinions until sure he is right, rules/regulations are very important, high morals, actions speak louder than words.

11. Patient: Tolerant, often hints rather than asks directly, accepting of others, always cheerful and easygoing, puts others at ease, wants security for self and others, wants peace at all costs, has a difficult time saying no to others, uncomfortable expressing their own needs, may tend to sweep problems under the rug.

12. Accomplishing: Energetic, always on the go, works fast, plays fast, laughs or smiles a lot, effervescence is contagious, wants approval and tries hard to get it, spontaneous, easily sidetracked, sense

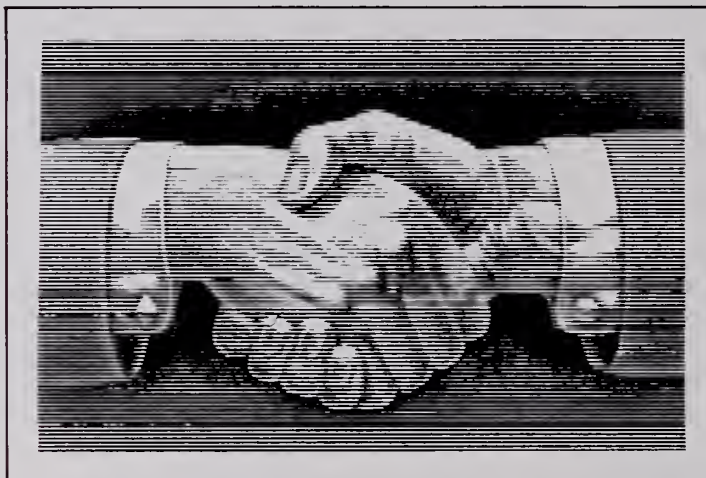
of humor, can exaggerate things, strives for recognition, the world is a stage for you.

Gregory G. Young, MD, has a private psychiatric practice in Dayton.

REFERENCES

- Falk-Kessler, J. Froschauer, K.: "The Soap Opera: A Dynamic Group Approach for Psychiatric Patients." *Am. J. of Occup. Ther.*, 32(5):317-319, 1974.
- Wilmer, H.: "Use of Television Monologue with Adolescent Psychiatric Patients." *Am. J. of Psychia.*, 126(12), 1760-1766, 1970.
- Young, G.: "Your TV Twins," New York, Fawcett-Columbine, 1987.
- Lickorish, J.: "The Therapeutic Use of Literature." *Psychother.* Theo., Research and Prac., 12(1): 105-109, 1975.
- Sciabassi, S.: "Literature as a Therapeutic Tool: A Review of the Literature on Bibliotherapy." *Am. J. of Psychother.*, 27(1): 70-77, 1973.
- 1987 Nielsen Report on Television.

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RECOGNITION OF SKIN CANCERS: SKIN CANCER AWARENESS PROGRAMS IN OHIO

Paul G. Hazen, MD

Skin cancers represent the most common and most curable of all malignancies. Early recognition and treatment can significantly decrease the morbidity and mortality associated with these neoplasms. To that end, the American Academy of Dermatology, the Ohio Dermatologic Association, and the American Cancer Society have organized a program of public education designed to improve the recognition of these tumors. Clinical aspects of the most common forms of skin cancers and a description of the Cancer Awareness Program are detailed.

Introduction

It is estimated that 500,000 people will develop skin cancer this year. Indeed, about one in every three new cancers is a skin cancer and about one in seven Americans will develop skin cancer in their lifetime.¹ The common nature of these malignancies makes their recognition crucial.

Important skin lesions may generally be considered premalignant or malignant. Examples of premalignant lesions would be actinic keratoses and dysplastic nevi. Malignant processes of skin include basal cell carcinomas, squamous cell carcinomas and malignant melanomas.

The purpose of this article will be 1) to review clinical characteristics useful in identifying premalignant and malignant lesions, and 2) to describe a public education and screening program concerning skin cancer in Ohio.

Premalignant lesions

Almost all skin cancers and premalignant skin lesions are thought to be related to sun-exposure, especially that acquired during the first 20 years of life.² Sun-exposed areas are, therefore, the most common sites for their occurrence.

Actinic (solar) keratoses represent abnormal areas of keratinization. Lesions are rough, scaly and firm to palpation. They

commonly occur on the face, scalp, ears, lips and/or arms. They may evolve into squamous cell carcinomas.

Dysplastic nevi represent atypical-appearing moles that may undergo transformation to malignant melanomas. These lesions are often present on the trunk and are characteristically slightly larger (>0.5 cm) than normal nevi, and have pink or irregular coloring (Fig. 1). If a family history of melanomas is present, the risk of melanoma may be as high as 100 percent.

Malignant lesions

Basal cell carcinoma is the most common of all skin malignancies, representing about 80 percent of all skin cancers. Tumors gradually occur in areas subjected to chronic sun-exposure and may take several forms. Superficial basal cell carcinomas are usually slowly enlarging, slightly erythematous lesions, often with central "clearing" and an elevated, pearly border (Fig. 2). Nodular basal cell carcinomas are often indurated, pearly-appearing and with superficial telangiectasias; hemorrhagic crusting may be present (Fig. 3). These tumors usually grow slowly and by direct extension; metastases are rare, but local destruction can be extensive.

Squamous cell carcinomas are the next most common skin malignancy, occurring in 80,000-100,000 patients each year in the U.S. Like basal cell carcinomas, lesions generally occur in areas of chronic sun-exposure. Tumors usually show a nodular, infiltrative process, often with ulceration, crusting and drainage (Fig. 4). Metastasis, although uncommon, can occur.

Malignant melanoma is the most serious of skin malignancies. These are rapidly increasing in incidence and it is estimated that by the year 2000, one person in 90 will develop a malignant melanoma.¹ It is projected that there will be 27,300 new cases diagnosed in 1988 and that 5,800 persons will die from their tumor. Lesions may occur in nearly any area of the body.

Lentigo maligna (melanoma) generally occurs in sun-exposed areas of the elderly individual. It is a slowly-enlarging pigmented lesion with irregular margins (Fig. 5). With deeper penetration, metastasis may occur.

Superficial spreading malignant melanoma is the most common form of melanoma. The age group from late teens to late 40s is most often affected. Lesions are usually enlarging, irregularly pigmented lesions with irregular, asymmetrical borders. A notch is often present and variegation in color (the red, white and blue mole) is often observed (Fig. 6). Prognosis is related to thickness.

Paul G. Hazen, MD, is chairman of the Skin Cancer Screening Committee of the Ohio Dermatological Association.



Figure 1



Figure 2

Acral-lentiginous melanomas are usually on the hands or feet (Fig. 7). They are the most common melanomas in black and Hispanic patients, and metastasize early. Prognosis is again related to thickness of the tumor.

Nodular melanomas are often found on the trunk area of males in the 50s to 70s. Lesions may have prominent or minimal pigmentation. Because of their penetrating nature, the potential for metastasis in these lesions is great.

Community education and screening programs

The American Academy of Dermatology, in association with regional medical societies and the American Cancer Society, has developed programs of education and community screenings concerning skin cancer. The month of May has been designated National Melanoma/Skin Cancer Detection and Prevention Month. Ohio presented programs in association with Skin Cancer Awareness Week, May 16-21.

At appointed times during that week, patients throughout Ohio had the opportunity to have their skin examined, at no cost, by a dermatologist. Associated with skin cancer screenings, educational programs emphasizing ways to avoid skin cancers through protection from the sun were offered. Screenings were held in Akron, Canton, Cincinnati, Cleveland, Columbus, Dayton, Medina, Toledo, Warren, Wooster and Youngstown.

Conclusion

It is hoped that through this Ohio program of public and physician education, both 1) prevention of sun-related skin problems and 2) recognition of cancerous lesions of skin may be improved. In such a program, patients or physicians observing any suspicious lesions will have the opportunity for further evaluation to take place at no cost.

REFERENCES

1. American Academy of Dermatology, press release, 1988.
2. Urbach F, et al.: Ultraviolet radiation and skin cancer in man, in Montagna, W, Dobson, RL (eds): *Advances in Biology of Skin*. New York, Pergamon Press, 1966, Vol. 7, pp. 195-214.



Figure 3

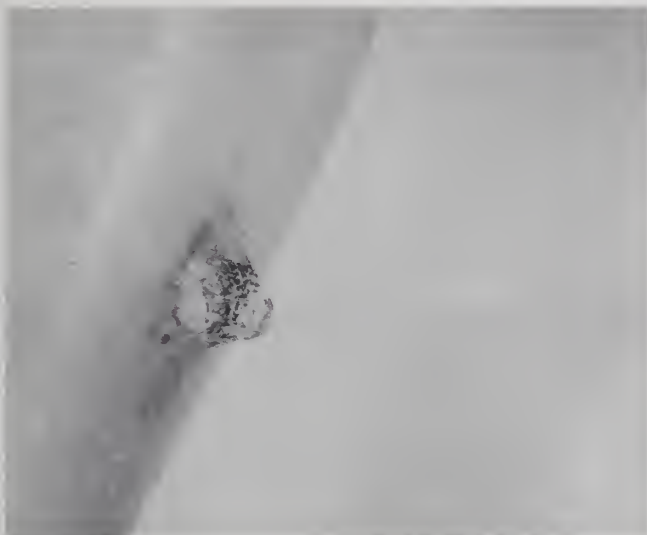


Figure 4

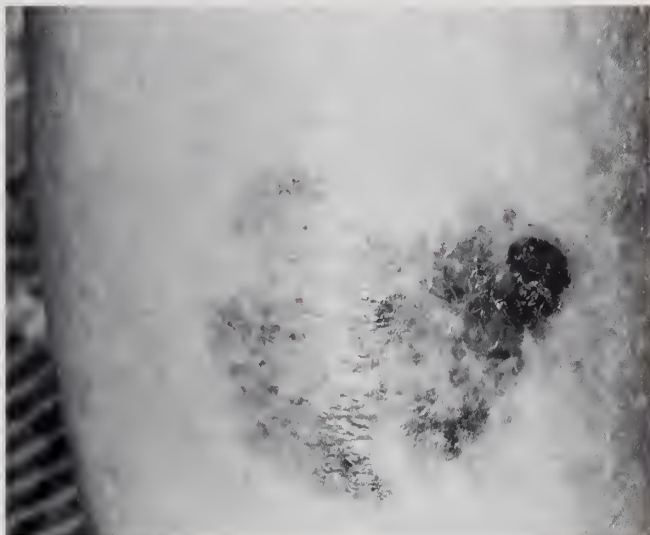


Figure 6



Figure 5



Figure 7

A SURVEY OF PHYSICIAN BELIEFS AND PRACTICES CONCERNING ROUTINE MAMMOGRAPHY

Suzanne E. Slenker, PhD
Jeanne M. Wright, RN, MEd

Annual mammography screening for women over 50 continues to be underutilized in the U.S. A Toledo-area survey was undertaken in May-June 1987 to investigate physician attitudes and practices toward screening mammography. Approximately one-half (110) of the 224 Toledo-area physicians responded to the questionnaire. Although 58% of respondents recommended annual mammography for at least 75% of their female patients 50 years and older, referral practices differed among specialties.

Only 31% of physicians favored patient self-referrals for mammography. Physicians' perceptions regarding the efficacy and risks of mammography as well as their perceptions of patient attitudes toward mammography screening were examined.

Introduction

The early detection of breast cancer is promoted by the regular use of three types of screening: breast self-exam, clinical breast examination and mammography. Physicians play a crucial role in the promotion or utilization of these three screening

methods. Fox, Baum, Klos, et al.¹ assessed women's compliance with American Cancer Society recommendations for these three types of screening. These authors found reasonable rates of compliance for BSE (53%-69%) and clinical examinations (70%-78%). In contrast, only 25% of women older than 50 had undergone a minimum of a baseline mammogram and one repeat mammogram.

The American Cancer Society recommends a baseline mammogram for asymptomatic women aged 35 to 40 years, regular mammograms annually or biennially for women between the ages of 40 and 49 years, and annually for all women aged 50 years or more.² Patient and physician variables can contribute to the underutilization of mammography. This study involving 110 Toledo-area physicians from various specialty areas examined physicians' perceptions and beliefs about the mammography procedure and recommendations for its use in the detection of breast cancer in women over 40 years.

An estimated 130,000 new cases of breast cancer in the United States was predicted to occur during 1987. Approximately one out of 10 women will develop breast cancer at some time during her life.³ Breast cancer is presently the most common form of cancer among women in this country and 75% of all breast cancers are detected in women over age 50.⁴ Every 15 minutes one woman dies of this disease.⁵

Breast cancer can be diagnosed radiologically with mammography at an extremely early and highly curable stage. By comparison, other common imaging techniques such as gastrointestinal examination to diagnose cancer of the esophagus, computed tomography to detect pancreatic cancer, and chest

Suzanne E. Slenker, PhD, is an assistant professor in the Department of Health Promotion and Human Performance at the University of Toledo; Jeanne M. Wright, RN, MEd, is a research assistant in the same department.

Table 1
Reported Percentage of Female Patients Over 50 Years
Who Are Referred for Mammography Yearly
or Every Two Years
by Physicians According to Specialty

Percentage of Patients Referred by Physician for Mammography Yearly or Every Two Years	Specialty (%)				
	OB/GYN (n = 29)	Internal Medicine (n = 23)	Family Practice (n = 29)	General Surgery (n = 26)	All Respondents (n = 110)
Under 25%	3.4	13.0	27.6	7.7	12.7
25 to 49%	10.3	21.7	27.6	3.8	15.5
50 to 74%	10.3	13.0	—	15.4	9.1
Over 75%	75.9	52.2	34.5	69.2	58.2
Cannot Estimate	—	—	10.3	3.8	4.5

radiographs in most lung cancers have little impact on prognosis.⁶

Mammography, defined as soft tissue roentgenography of the breast, has been available since the first half of the 20th century.⁷ Mammography has been commonly utilized to evaluate breasts of symptomatic women with clinical findings of breast lumps, nipple discharge or mastalgia. Mammography has also been effective in detecting occult cancer of the contralateral breasts in patients with a history of breast cancer. In recent years, use of mammography has been expanded to include periodic breast screening in asymptomatic women.

Recent studies support theories that mammography in combination with physical examination will reduce mortality from breast cancer in women over the age of 50. A 38% reduction in mortality in the first five years was revealed in the Health Insurance Plan of the Greater New York Study (HIP). Screening with mammography and physical examination took place from December 1963 through June 1970, and follow-up continued through the 1980s. Aron and Prorak analyzed the HIP study data from time of entry through December 1981. They estimated that 40 breast cancer deaths from among 132 screen-detected cases were prevented.⁸

Another screening study in Nijmegen, Netherlands, examined the reduction of mortality from early detection of breast cancer. In this screening study, 30,000 women were invited for X-ray mammography every two years from 1975 to 1981. The results indicated that mortality rate from breast cancer in the age group 35 and over can be reduced by approximately 50% at seven years by periodic mammography screening.⁹

The combination of optimal breast self-examination, optimal physical examination and optimal mammography offers the best opportunity for early detection of breast cancer. Mammography has been described as the most effective available method

Table 2
Reported Percentage of Mammograms Recommended by
Physicians for Screening Purposes
in Asymptomatic Women Over 50 Years

Percentage of Mammograms for Screening Pur- poses in Asymp- tomatic Women Over 50 Years	Specialty (%)				
	OB/GYN	Internal Medicine	Family Practice	General Surgery	All Respondents
Under 25%	6.9	8.7	20.7	7.7	11.8
25 to 49%	—	21.7	20.7	30.8	17.3
50 to 75%	7.2	13.0	6.9	26.9	16.4
Over 75%	75.9	56.5	41.4	19.2	48.2
Cannot Estimate	—	—	10.3	11.5	5.5
No Response	—	—	—	3.8	.9

capable of detecting breast cancers in their minimal, nonpalpable and most curable stage.¹⁰ For this reason, the underutilization of mammography in asymptomatic older women is of great concern.

Subjects and Methods

In April 1987, questionnaires were mailed with a cover letter explaining the purpose of the study to 234 physicians in the Toledo area. This study group was comprised of physicians listed in the yellow pages of the Toledo-area phone directory who were included under specialty areas of internal medicine, family practice, obstetrics and gynecology, and general surgery. The survey sought general demographic information and specific responses to assess physician beliefs concerning the use of mammography in screening women over 40 years old. A Likert-type scale was utilized to evaluate physician responses.

Nonrespondents were sent another copy of this questionnaire in May of 1987, four weeks after the initial mailing, with a cover letter urging their participation. Of the 234 physicians in the sample, 10 were dropped. Of these 10 questionnaires, six were discarded since the questionnaires returned with postmark notations of incorrect addresses. The other four discarded questionnaires were from physicians who reported practicing in an unrelated specialty (ophthalmology). Of the 224 remaining physicians, 110 completed the questionnaire, yielding an overall response rate of approximately 50% (49.2%).

Sixty-five percent of physicians who responded were male, while 6% of respondents were female. Approximately 29% of physicians surveyed did not answer this question. Of the 110 physicians surveyed, 67% were between the ages of 35 and 64 years. When physicians were divided according to specialty areas, OB/GYN comprised 26% of the total, internal medicine 21%, family practice 26%, and general surgery 24%. Three respondents did not indicate a specialty.

Results and Discussion

Fifty-eight percent of the Toledo-area physicians surveyed reported that they recommended annual mammography for at least 75% of their female patients 50 years and older. Overall,

The authors gratefully acknowledge the assistance of Roland T. Skeel, MD, professor of medicine and chief, Division of Hematology/Oncology, Medical College of Ohio, Toledo, Ohio, in construction of the survey.

family practice and internal medicine physicians were less likely to order annual mammograms for both asymptomatic and symptomatic women over 50 when compared to OB/GYN and general surgeons. Seventy-six percent of OB/GYNs and 69% of general surgeons reported that they referred over 75% of their female patients for annual/biennial mammograms. In comparison, only 52% of internal medicine physicians and 35% of family practice physicians reportedly referred over 75% of their female patients for annual mammograms (Table 1). According to a physician mail survey study reported by Bassett, Bunnell, Cerny, et al., only 11% of physician respondents followed ACS guidelines for mammography.¹¹ These authors cited a 1984 study of 1,035 primary care physicians which revealed that OB/GYNs were more apt to follow ACS guidelines than general practitioners, family physicians or internists.

Screening mammograms for asymptomatic women over 50 years were reportedly ordered most frequently by OB/GYN physicians while general surgeons prescribed screening mammograms less frequently than any other specialty of physicians (Table 2). More than likely, the lower rate of prescribed mammograms among general surgeons would be due in part to their specialty since they tend to treat symptomatic women with breast problems who were referred to them by other physicians. Therefore, the proportion of screening mammographies prescribed would be less than diagnostic mammograms ordered.

Hall editorialized that the medical community is in general agreement with the recommendations of the American Cancer

Society, American College of Radiology, National Cancer Institute, American College of Obstetrics and Gynecology, and American Academy of Family Physicians that women should have a baseline mammogram at the age of 35 to 40 years.¹² Present study findings support Hall's editorial. Over 75% of physicians in each specialty area agreed that women between the ages of 35 and 40 years should have a baseline mammogram (Table 3). Mahoney and Csima, on the other hand, reported that mammography under the age of 35 years is unrewarding. Since mammography is an imaging technique, the authors believe that its efficiency decreases with young women whose normal breast parenchyma has not yet been replaced by fat.¹³

Ninety-three percent of all physician respondents agreed that women over 40 with a strong familial history should undergo yearly mammography (Table 3). Women who have a family history of breast cancer are extremely vulnerable to cancer of the breast, especially when a first-degree relative (i.e., mother, daughter or sister) has had the disease. The risk increases further if that relative developed breast cancer before age 50. If the relative had bilateral (synchronous or metachronous) breast cancers, the risk is even greater.¹⁴ Bassett, Bunnell, Cerny, et al. also found that physicians frequently recommended regular mammograms in women with strong personal or family history of breast cancer. Yet these authors caution that 75% of women with breast cancer do not have these risk factors.¹⁵

A major factor in the underutilization in mammography is a low referral rate of patients from their personal physician.

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Table 3
Physicians' Beliefs About Prescribing Mammography
for Screening Purposes

Beliefs	Percentage of Physicians in Agreement with Belief According to Specialty				
	Specialty				
	OB/GYN (n = 29)	Internal Medicine (n = 23)	Family Practice (n = 29)	General Surgery (n = 26)	All Respondents* (n = 110)
1. Women between the ages of 35 and 40 years should have a baseline mammogram.	75.8 (n = 22)	78.2 (n = 18)	79.0 (n = 20)	84.6 (n = 22)	76.4 (n = 84)
2. Yearly mammography should be recommended for women over 40 with a strong familial history.	96.5 (n = 28)	95.7 (n = 22)	86.2 (n = 25)	92.3 (n = 24)	92.7 (n = 102)
3. Women over 40 years should be able to have a mammogram done without consulting their physician.	31.0 (n = 9)	30.4 (n = 7)	17.2 (n = 5)	50.0 (n = 13)	30.9 (n = 34)

*This category includes three respondents who did not indicate a specialty.

Bird and McLelland have recommended the initiation of low-cost screening mammography centers.¹⁶ They have suggested assessing attitudes of physicians concerning patient self-referrals and promoting the concept of patient self-referral to physicians.

Survey results (Table 3) disclose that family practice physicians were most resistant to the idea of patient self-referrals. Only 17.2% of family practice physicians agreed that women over 40 should be able to have a mammogram done without consulting their personal physician. OB/GYN and internal medicine physicians were slightly less resistant, while general surgeons were most receptive to the idea of self-referral. Overall, 31% of all physician respondents were in favor of patient self-referrals (Table 3). Reasons for physician resistance to patient self-referrals were not investigated in this study.

Of the Toledo-area physicians sampled, 85% agreed that mammography represented the most effective, accurate and reliable method for the detection of breast cancers in the early stage for women 40 years and over (Table 4). Concurrently, 92% of all respondents believed mammography was proven effective in detecting breast cancers too small to be felt by the most experienced examiner (Table 4). General surgeons (96%) were most confident in the efficacy of mammography in the detection of non-palpable breast cancers (Table 4).

Technical advances and increased expertise in mammographic interpretation by radiologists have made mammography the most effective, single procedure available for detecting very small, localized breast cancers.¹⁷ X-ray mammography has been described as the only method capable of detecting clustered microcalcifications which are less than 1mm in diameter. These calcifications frequently have been associated with malignant lesions and are often the only indications of occult and early-stage disease.¹⁸

The effectiveness of mammography in differentiating fibrocystic disease from breast carcinoma has been debated. Overall, 87% of all physician respondents believed mammography was a useful tool in the differentiation of fibrocystic breast disease from breast cancers (Table 4). Variations in mammography specificity may occur because patients with fibrocystic breast disease are more difficult to interpret roentgenographically. Lamas, Horowitz and Peck concluded that the specificity of mammography was higher for patients with clinically benign breasts than with fibrocystic breast disease.¹⁹ On the other hand,

mammography together with ultrasound can be helpful adjuncts in the differentiation process. Ultrasound alone can rarely reveal occult lesions under 1 cm or microcalcifications, yet mammography can. However, ultrasound can help to differentiate cystic from solid masses. Ultrasound can reveal true cystic characteristics of lesions and guide successful aspiration and resolution of the mass, avoiding surgery.

In a 1983 study investigating physicians' attitudes about mammography, the most common reason given by physicians for not recommending mammography in asymptomatic women was concern about radiation and possibility of cancer from radiation exposure.²⁰ In this study, only 12.7% of all physicians agreed that annual mammography should *not* be recommended to women over 40 years for reasons of exposure to unnecessary radiation (Table 5).

Although the radiation dose from current mammographic technique is extremely low (0.1-.8 rad [1-8 cm GY] mean glandular dose for a two-view examination), the possibility of risk from such studies has been raised because of the increased breast cancer incidence among female populations exposed to considerably higher doses (usually 100-2000 rad [1-20 Gy]).²¹

Projected benefits from screening have subsequently been compared to estimated values for radiation risk from mammography. The possible risk from radiation is a mean tissue dose of 170 mR from a modern mammographic study. This dose of radiation might theoretically result in one excess cancer per year per one million women.²² Similarly, other activities which increase the chance of dying by one in one million included smoking 1.4 cigarettes, drinking one-half liter of wine and traveling 16 km (10 miles) by bicycle or 590 km (300 miles) by car.²³ Moreover, radiation exposure in older women (after 35 years of age) appears to have less potential for inducing breast cancer than it does in younger women.²⁴ Fisher and Wickerman, after comparing benefit of early detection with theoretic radiation risk, concluded that benefits of mammography far outweigh the risks.²⁵

Physicians' perceptions that their patients would not accept their recommendations of mammography may be another deterrent to their use of mammography in screening. Cummings et al. reported that two-thirds of their physicians surveyed reported patients "often" or "sometimes" refuse mammography when it was suggested to them.²⁶ In the present study, various reasons

A Survey of Physician Beliefs . . . continued

Table 4
Physicians' Beliefs Concerning Efficacy of Mammography in Women Over 40 Years

Beliefs Concerning Efficacy of Mammography in Women Over 40 Years	Percentage of Physicians in Agreement With Belief Statements Concerning Efficacy of Mammography				
	Specialty				
	OB/GYN (n = 29)	Internal Medicine (n = 23)	Family Practice (n = 29)	General Surgery (n = 26)	All Respondents* (n = 110)
1. Useful tool in helping to differentiate fibro-cystic diseases of the breast from breast cancer.	82.7 (n = 24)	95.6 (n = 22)	93.1 (n = 27)	84.6 (n = 22)	87.3 (n = 96)
2. Proven effective in detecting breast cancer too small to be felt by the most experienced examiner.	93.1 (n = 27)	87.0 (n = 20)	89.6 (n = 26)	96.2 (n = 25)	91.8 (n = 101)
3. Most effective, accurate and reliable method for detection of breast cancers in the early stage.	82.8 (n = 24)	95.6 (n = 22)	79.3 (n = 23)	88.4 (n = 23)	85.4 (n = 94)

*This category includes three respondents who did not indicate a specialty.

for refusal given by female patients to their physician were examined. Sixty percent of physicians agreed that female patients sometimes refused mammography when recommended citing reasons of radiation, fear, pain or embarrassment. Physicians of internal medicine reported the greatest frequency of patient refusals (74%) due to the reasons previously given. General surgeons reported the least patient resistance to mammography testing (50%). However, surgeons would tend to recommend mammography to symptomatic women who may be more willing to undergo mammography than asymptomatic female patients.

In a 1984 study involving 4,200 physicians in the Los Angeles area, 55% gave high cost and low yield as major reasons for not screening.²⁷ Fifty-four percent of all physician respondents agreed that female patients have refused mammography because of costs, and 67% of physicians believed that the cost of mammography screening is not covered by some health insurance companies (Table 5). OB/GYN physicians surveyed reported the greatest frequency (69%) of patient resistance to mammography due to cost (Table 5). Cummings et al. explained that until evidence becomes available showing mammography screening to be cost effective, medical insurers are not likely to change their policies regarding reimbursement for mammography screening.²⁸ Devereaux-Melillo agrees that emphasis on preventative rather than episodic practices especially in the elderly population is not fostered by health-care reimbursement systems.²⁹

Efforts have been underway to initiate and operate low-cost screening mammography centers to off-set the cost deterrents. A low-cost mammography screening center was opened in Charlotte, North Carolina, in August 1985. Since that time, approximately 45 women per day have undergone mammography testing. Their actual cost per mammogram has been \$16 (excluding the interpretation fee of \$16). Prior to this facility opening, mammography being done in Charlotte averaged \$60 per test.³⁰ A similar facility may decrease costs in Toledo, but an analysis of financial feasibility would need to be done to predict financial success.

Summary

In April 1987, a survey of 234 physicians comprised of various specialty areas (obstetrics/gynecology, internal medicine, family practice and general surgery) was conducted in Toledo, Ohio. One hundred and ten physicians participated and their

responses concerning the routine use of mammography in women over 40 were evaluated.

Findings indicated 58% of the Toledo-area physicians surveyed prescribed annual mammograms for at least 75% of their female patients 50 years and older. Ninety-three percent of physicians surveyed agreed that women over 40 years with a strong familial history of breast cancer should undergo yearly mammography.

Physicians reportedly believed that mammography represented the most accurate and reliable method for detection of breast cancer in the early stage. Over 85% of physician respondents agreed with three statements highlighting the efficacy of mammograms. A belief that the hazards of radiation outweigh the benefits was not a high concern among respondents. Only 13% of physicians agreed that yearly mammography screening should not be recommended to women over 40 since the procedure would expose them to unnecessary radiation.

Sixty-nine percent of physician respondents were resistant to patient self-referrals for mammography screening. Further studies could investigate reasons for physicians' reluctance to support patient self-referrals for mammography.

Fifty-four percent of physicians responded that female patients have refused mammography when recommended due to cost, and 67% of physicians agreed that the cost of mammography screening was not covered by some health insurance companies. Further investigation of costs as deterrents in prescribing mammography should be undertaken.

Sixty percent of physician respondents agreed that female patients have refused mammography when recommended, due to reasons of radiation, fear, pain or embarrassment. It is plausible that physicians' reluctance to prescribe annual mammograms could be influenced by their anticipation of negative reactions from patients.

REFERENCES

1. Fox, S., Baum, J.K., Klos, D.S., et al.: Breast cancer screening: The underuse of mammography. *Radiology* 156:607-611, 1985.
2. Cancer Facts and Figures. New York: American Cancer Society, 1984.
3. Ibid.
4. Devereaux-Melillo, K.: Who needs health-care maintenance? *Journal of Gerontological Nursing* 11(2):18-21, 1985.
5. National Task Force on Breast Cancer Control. Mammography:

Table 5
Physicians' Reasons for Not Recommending Mammography for Asymptomatic Women

Reasons for Not Recommending Mammography for Asymptomatic Women	Physicians in Agreement with Reasons for NOT Recommending Mammography				
	Specialty				
	OB/GYN (n = 29)	Internal Medicine (n = 23)	Family Practice (n = 29)	General Surgery (n = 26)	All Respondents* (n = 110)
1. Exposes women to unnecessary radiation.	17.2 (n = 5)	13.0 (n = 3)	17.2 (n = 5)	3.8 (n = 1)	12.7 (n = 14)
2. Cost not covered by some insurance companies.	69.0 (n = 20)	82.6 (n = 19)	65.5 (n = 19)	50.0 (n = 13)	67.2 (n = 74)
3. Patient refusal due to cost of mammogram.	69.0 (n = 20)	47.8 (n = 11)	62.1 (n = 18)	30.7 (n = 8)	53.6 (n = 59)
4. Patient refusal due to pain, fear, embarrassment or radiation.	65.5 (n = 19)	73.9 (n = 17)	58.6 (n = 17)	50.0 (n = 13)	60.0 (n = 68)

*This category includes three respondents who did not indicate a specialty.

- A statement of the American Cancer Control, 1982.
6. Hall, F.M.: Screening mammography — Potential problems on the horizon. *New England Journal of Medicine* 314:53-55, 1986.
 7. Lamas, A.M., Horowitz, R.I., & Peck, D.: Usefulness of mammography in the diagnosis and management of breast disease in postmenopausal women. *JAMA* 252(21):2999-3002, 1984.
 8. Aron, J.L., & Prorok, P.C.: An analysis of the mortality effect in a breast cancer screening study. *International Journal of Epidemiology* 15(1):36-43, 1978.
 9. Bjornsson, S., Brekkan, A., & Tulinius, H.: Mass screening for breast cancer. *Scand J Soc Med* 14:3-6, 1986.
 10. Fox, S., Tsou, C.V., & Klos, D.S.: An intervention to increase mammography screening by residents in family practice. *The Journal of Family Practice* 20(5):467-471, 1985.
 11. Bassett, L.W., Bunnell, D.H., Cerny, J.A., et al.: Screening mammography: Referral practices of Los Angeles physicians. *AJR* 147:689-692, 1986.
 12. Hall, F.M.: Screening mammography. [Editorial]. *AJR* 47:195-196, 1986.
 13. Mahoney, L., & Csimas, A.: Use and abuse of mammography in the early diagnosis of breast cancer. *The Canadian Journal of Surgery* 26(3):262-265, 1983.
 14. Fisher, B., & Wickerham, L.: Answers to questions about breast cancer. *AFP* 33(4):214-222, 1986.
 15. Bassett, L.W., Bunnell, D.H., Cerny, J.A., et al.: Screening mammography: Referral practices of Los Angeles physicians. *AJR* 147:689-692, 1986.
 16. Bird, R.E., & McLelland, R.: How to initiate and operate a low-cost screening mammography center. *Radiology* 161:43-47, 1986.
 17. Cummings, M.K., Funch, D.P., & Mettlin, C.: Family physicians' beliefs about breast cancer screening by mammography. *The Journal of Family Practice* 17:1029-1034, 1983.
 18. Kopans, D.B.: Breast cancer detection. [Editorial]. *West J Med* 144:73-76, 1986.
 19. Lamas, A.M., Horowitz, R.I., & Peck, D.: Usefulness of mammography in the diagnosis and management of breast disease in postmenopausal women. *JAMA* 252(21):2999-3002, 1984.
 20. Kopans, D.B., Meyer, J.E., & Sadowsky, N.: Breast imaging. *New England Journal of Medicine* 310(15):960-967, 1984.
 21. Feig, S.A.: Radiation risk from mammography: Is it clinically significant? *AJR* 143:469-475, 1984.
 22. National Task Force on Breast Cancer Control. Mammography: A statement of the American Cancer Control, 1982.
 23. Kopans, D.B., Meyer, J.E., & Sadowsky, N.: Breast imaging. *New England Journal of Medicine* 310(15):960-967, 1984.
 24. Cummings, M.K., Funch, D.P., & Mettlin, C.: Family physicians' beliefs about breast cancer screening by mammography. *The Journal of Family Practice* 17:1029-1034, 1983.
 25. Fisher, B., & Wickerham, L.: Answers to questions about breast cancer. *AFP* 33(4):214-222, 1986.
 26. Cummings, M.K., Funch, D.P., & Mettlin, C.: Family physicians' beliefs about breast cancer screening by mammography. *The Journal of Family Practice* 17:1029-1034, 1983.
 27. Bassett, L.W., Bunnell, D.H., Cerny, J.A., et al.: Screening mammography: Referral practices of Los Angeles physicians. *AJR* 147:689-692, 1986.
 28. Cummings, M.K., Funch, D.P., & Mettlin, C.: Family physicians' beliefs about breast cancer screening by mammography. *The Journal of Family Practice* 17:1029-1034, 1983.
 29. Devereaux-Melillo, K.: Who needs health care maintenance? *Journal of Gerontological Nursing* 11(2):18-21, 1985.
 30. Bird, R.E., & McLelland, R.: How to initiate and operate a low-cost screening mammography center. *Radiology* 161:43-47, 1986.

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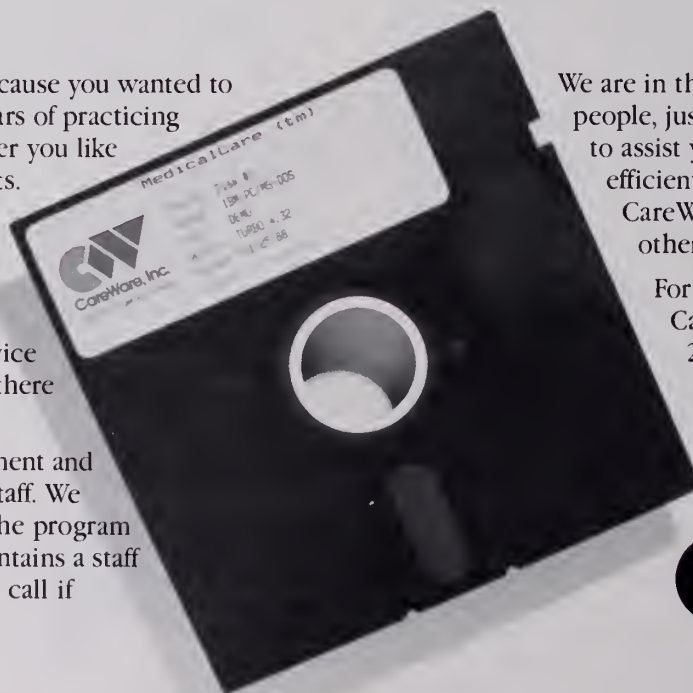
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VALVE REPLACEMENT FOR AORTIC STENOSIS AND REGURGITATION: A THREE-YEAR EXPERIENCE

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Aortic valve replacement for stenosis or regurgitation was carried out in 50 patients, either as an isolated procedure or combined with myocardial revascularization, for an overall operative mortality of 6%. This report analyzes our experience with this distinct subgroup of patients and reviews the current status of aortic valve replacement with regard to patient evaluation and selection, operative risks, valve substitutes and prognosis.

Introduction

Valve replacement is the definitive management for adult patients with severe aortic stenosis or regurgitation. Prior to the development of reliable prosthetic devices or the use of homografts in the early 1960's, the outlook for such patients was dismal. Progressive congestive heart failure, irreversible ventricular damage, and sudden death were inevitable, as direct surgical repair of the native aortic valve, even as a palliative measure, is feasible only in infants and young children. With continued improvements in anesthetic and surgical techniques, perioperative care, and prostheses, aortic valve replacement has now become quite safe and commonplace in larger centers.

In a retrospective review of 1,000 consecutive patients undergoing open heart surgery by our group at the Mount Carmel Medical Center in Columbus in the interval January 1983 through November 1985, 50 patients underwent aortic valve

replacement as an isolated procedure or combined with myocardial revascularization. This report analyzes our experience with this distinct subgroup of patients and reviews the current status of aortic valve replacement with regard to patient evaluation and selection, operative risks, valve substitutes and prognosis.

Materials and Methods

Patients were initially evaluated because of an asymptomatic cardiac murmur or presentation with cardiac or cerebrovascular symptoms. Complete cardiac catheterization was carried out in each instance, with additional studies for assessment of ventricular function when indicated. Virtually all patients were accepted as operative candidates, in the absence of medical contraindications or severe and irreversible impairment of left ventricular function. In general, valve replacement was indicated for patients with symptomatic aortic valve disease, in those with aortic stenosis and significant transvalvular pressure gradients, and in those with aortic regurgitation and left ventricular decompensation. Aortocoronary bypass grafting was carried out concomitantly for stenoses of greater than 50% of luminal diameter in major vessels.

All procedures were carried out using standard cardiopulmonary bypass, moderate systemic hypothermia, and cold potassium cardioplegia infused directly into the coronary ostia or saphenous vein grafts. Excision of the native aortic valve, insertion of the replacement valve, and distal vein graft to coronary anastomoses were all carried out during a single anoxic interval. All valves were placed with interrupted polyester sutures reinforced by Teflon pledgets using a transaortic approach. Postoperative care was routine; patients with coronary bypass grafting were treated with antiplatelet agents when possible, and those with mechanical valves were placed on Coumadin anti-

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coagulation usually beginning on the second post-operative day. All surviving patients were followed by periodic office visits.

Results

The 50 patients ranged in age from 22 to 86 years, with a mean of 61 years. There were 34 men and 16 women; females manifested a wider age range and tended to be older than males (22 to 86 years, mean 68 years, versus 25 to 76 years, mean 58 years, respectively). Four patients had undergone previous aortic valve replacement and required reoperation for tissue valve leaflet degeneration or prosthetic dysfunction. The primary diagnosis was aortic stenosis in 34 patients (68%), aortic regurgitation in 13 patients (26%), and combined pathology in three patients (6%). Mean transvalvular gradient for those with aortic stenosis was 74 millimeters of mercury (range 40-130 mm). In cases of aortic stenosis, it was often impossible to determine the precise etiology on the basis of the clinical history; severe calcific changes, often due to congenitally abnormal valves, were commonly encountered intraoperatively. Myxomatous degeneration of native valve leaflets were found in all cases of aortic regurgitation.

Isolated aortic valve replacement was carried out in 37 patients and combined with coronary artery bypass grafting in 13 patients; in the latter group, a mean of 1.5 grafts per patient (range 1-3) was performed. Tissue (porcine) valves were inserted in 44 instances (88%) and mechanical valves were inserted in six instances (12%).

A total of 11 additional operative procedures were carried out during the same admission, most commonly reoperation for bleeding (5 cases), tracheostomy (2), and pacemaker insertion (2). There were 17 complications, including atrial or ventricular arrhythmias which prolonged the hospital stay (7 cases), renal insufficiency (3), congestive heart failure (2), respiratory failure (2), urinary tract infection (2) and stroke (1).

Among patients undergoing isolated aortic valve replacement there was one death (2.7%) and among patients undergoing aortic valve replacement with aortocoronary bypass there were two deaths (15%), for an overall operative mortality of 6%. One patient experienced cardiac arrest preoperatively and ultimately died from multisystem failure during a difficult hospital course; a second patient succumbed on the thirteenth post-operative day due to intractable ventricular arrhythmias; and a third expired due to low cardiac output syndrome occurring intraoperatively. The latter two patients had undergone valve replacement with concomitant coronary bypass. Median hospital stay for surviving patients was 12 days (range 7-150 days). Follow-up was obtained in all survivors a median of nine months after operation; there were no thromboembolic events, complications related to anticoagulation or late deaths.

Discussion

Aortic valve replacement represents a drastic surgical procedure and the decision to proceed with operation is difficult in many instances, particularly in asymptomatic patients. The situation is complicated by the fact that aortic valve disease in

adults generally progresses slowly, with relatively low risks during a long asymptomatic phase. With the onset of symptoms, however, the prognosis rapidly deteriorates and most patients succumb within a few years without surgical intervention.

In the case of aortic stenosis, survival curves reveal that the period from onset of symptoms until death usually lasts less than five years, with "sudden death" occurring in up to 20% of patients. Angina, syncope and congestive heart failure occur in three-fourths of symptomatic patients, with congestive heart failure being the most ominous sign.¹ Following establishment of a definitive diagnosis, operative intervention is almost always indicated in such instances, with the main contraindication being severe impairment of ventricular function resulting in prohibitive operative risk. Asymptomatic patients with aortic stenosis, on the other hand, are usually evaluated because of a cardiac murmur, and valve replacement is usually recommended on the basis of a transvalvular pressure gradient of at least 50 millimeters of mercury. Occasional instances of critical aortic stenosis occur with lower measured valve gradients, a situation seen with decreased cardiac outputs or congestive failure, and recommendation for operation must be interpreted in view of these other circumstances. Although the perioperative mortality of aortic valve replacement varies, an acceptable risk is probably in the range of 5%.² Associated coronary artery disease, abnormal ventricular function, and pulmonary hypertension are all indicators of the patient at high risk.³ This indeed was the case in the present series, with only a 2.7% operative mortality for isolated aortic valve replacement, but a 15% mortality in those patients requiring concomitant grafting for coronary disease. In addition to its other advantages in relief of symptoms and improvement in quality of life, the relatively low risk of aortic valve replacement in the case of aortic stenosis appears warranted in its ability to prevent sudden death.^{2,4,5}

Aortic regurgitation is an indolent condition and symptoms are almost always the consequence of elevated pulmonary venous pressure, ranging from mild dyspnea on exertion to pulmonary edema. Valve replacement must usually be performed in such symptomatic patients, and in contrast to aortic stenosis, it is almost never "too late" to proceed with replacement surgery for aortic regurgitation. Most long-term, follow-up data indicate that aortic valve replacement enables substantially longer survival than medical therapy in these instances.^{2,4}

Some difficulty may arise in the work-up of patients with asymptomatic aortic regurgitation, with regard to selection of operative candidates and timing of intervention. These patients can be divided into those with normal and those with abnormal ventricular function, each with a different natural history. On the one hand, asymptomatic patients with normal left ventricular function have an excellent prognosis despite considerable cardiomegaly; symptoms develop slowly and operation can be postponed until symptoms appear or cardiac function deteriorates.⁶ On the other hand, asymptomatic patients with abnormal ventricular function, as demonstrated by cardiac catheterization, radionuclide techniques and echocardiography, require

Continued on page 486

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Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.



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Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped so as to be occluded (see **DOSAGE AND ADMINISTRATION**).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid. Urinary free cortisol test, ACTH stimulation test.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetate. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetate Cream cleared or significantly ameliorated the disease state in most patients. Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio. HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

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Valve Replacement . . . continued

valve replacement to avoid further decompensation and high operative risk.⁷

There are two classes of replacement valves currently in use worldwide, tissue valves and mechanical valves, each with its own advantages and disadvantages. The most popular and successful of the tissue valves over the past decade is the porcine valve, a hybrid or "bioprosthesis," consisting of animal aortic valve leaflets which have been fixed in glutaraldehyde and mounted on a rigid prosthetic stent. Multiple sizes are available and with minor modifications are applicable for use in any of the four cardiac valve positions. Since the nonmoving, cloth-covered, prosthetic surfaces rapidly become incorporated by recipient tissue, only the functional leaflets are exposed to blood flow, which in the aortic position is very brisk, allowing for a relatively non-thrombogenic device. Most patients with porcine aortic valves are, therefore, spared the risk and inconvenience of long-term anticoagulation. Unfortunately, the problem of tissue valve wear has not been fully solved. Although changes in the leaflets such as calcification, stiffening, perforation and tearing usually occur slowly and allow planning for subsequent repeat intervention, the necessity for reoperation in many patients with these valves after 8-10 years remains a significant disadvantage.

There is no ideal valve substitute and the multiplicity of mechanical valve prostheses developed, used and then abandoned over the past 25 years attests to their imperfections as well. These devices, engineered as peripheral flow (ball) or central flow (disc) design, are constructed with metallic alloys and materials made to resist the equivalent of hundreds of years of cardiac cycles. Although durability is their forte, mechanical valves are highly thrombogenic, and all patients with such devices require Coumadin anticoagulation for life.

After many years of use, it is apparent that problems with prosthetic aortic valves are not inconsequential, with valve-related thromboembolism, serious bleeding due to anticoagulation, valve dysfunction and infective endocarditis each occurring at rate of at least 1% per year. Therefore, the frequency of serious complications of prosthetic valves is approximately 5% per year, with death directly due to the prosthesis occurring in the range of 1-2% per year.⁸ Interestingly, and despite these drawbacks, patient survival in the current era of aortic valve replacement depends primarily on patient factors and not on the type of valves employed; survival is 70-88% at five years and 60-78% at 10 years.⁹

Except in unusual instances in which the aortic annulus is small and a low profile mechanical device is required, the physician and often the patient have the ability to select in advance the type of replacement, either porcine valve or mechanical prosthesis, for use in the aortic position. The decision is one of thrombogenicity versus durability. For example, a vigorous man who plays contact sports, a young woman who plans future pregnancies, or an older patient with a history of ulcer disease, may all best have porcine aortic valves and avoid long-term anticoagulation, with the understanding that reoperation is likely for repeat valve replacement in future years. A more sedentary young patient or one already on long-term anticoagulation for other reasons, on the other hand, may best have a mechanical aortic valve, and hopefully avoid future reoperation. In contrast to mitral valve replacement, in which Coumadin, even for porcine valves, is usually advisable because of chronic atrial fibrillation, a porcine valve in the aortic position affords the luxury

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of not requiring anticoagulation. Thus, the overwhelming majority of our patients with aortic valve disease have received porcine valves with which we have been quite satisfied from the standpoint of hemodynamic performance, low thrombogenicity, and patient acceptance. Reoperative cardiac surgery can now be carried out safely, and when many of these patients ultimately come to reoperation, the next generation of tissue valves then available will hopefully be even more favorable.

In the fashion of angioplasty for coronary disease, there has been recent enthusiasm for percutaneous balloon valvuloplasty as a palliative measure for some patients with aortic stenosis.⁹ It is difficult to envision the feasibility of such a technique, as prosthetic replacements were developed out of necessity, since the stenotic end stage aortic valve cannot be made functional even under direct vision. At the time of operation, most such valves are found to be an amorphous mass of fibrosis and calcium, and bone instruments are usually necessary for their excision. The statement that balloon dilatation "gives a degree of suppleness back to the valves" is therefore absurd and implies lack of knowledge of the underlying pathology. Nevertheless, balloon valvuloplasty remains an exciting alternative for the select few patients who would otherwise be inoperable.

During the past three decades, remarkable strides have been made in the field of aortic valve replacement in terms of diagnostic techniques, perioperative management and biomedical engineering. The future of aortic valve replacement lies in the development of a non-thrombogenic, infinitely durable valve

substitute, such that patients with life threatening aortic valve disease can be promised vigorous future years without the necessity for reoperation.

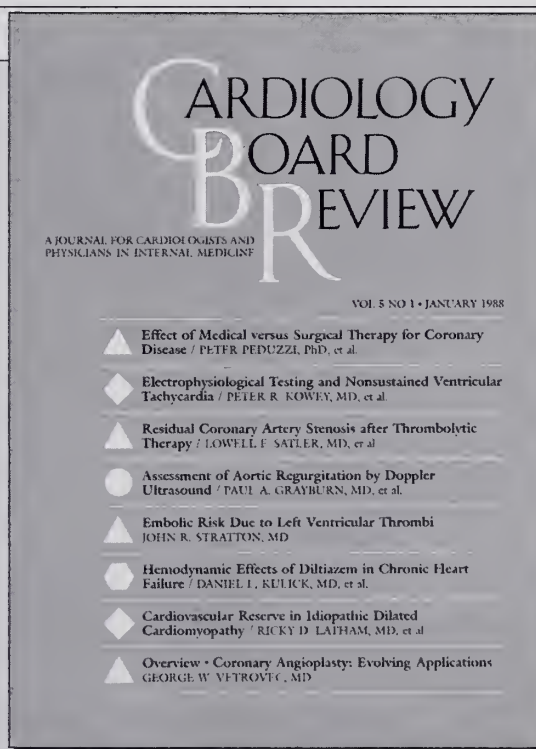
REFERENCES

1. Ross J Jr, Braunwald E: Aortic stenosis. *Circulation* (Suppl 5) 35:61; 1968.
2. Macmanus Q, Grunkemeier GL, Lambert LE, et al: Year of operation as a risk factor in the late results of valve replacement. *J Thorac Cardiovasc Surg* 80:834; 1980.
3. McHenry MM, Rice J, Matlof HJ, et al: Pulmonary hypertension and sudden death in aortic stenosis. *Br Heart J* 41:463; 1979.
4. Copeland JG, Griep RB, Stinson EB, et al: Long-term follow-up after isolated aortic valve replacement. *J. Thorac Cardiovasc Surg* 74:875; 1977.
5. Cohn LH: The long-term results of aortic valve replacement. *Chest* 85:387; 1984.
6. Bonow RO, Rosing DR, McIntosh CL, et al: The natural history of asymptomatic patients with aortic regurgitation and normal left ventricular function. *Circulation* 68:509; 1983.
7. Borow KM, Green LH, Mann T, et al: End-systolic volume as a predictor of postoperative left ventricular performance in volume overload from valvular regurgitation. *Am J Med* 68:655; 1980.
8. Murphy ES, Kloster FE: Late results of valve replacement surgery II. Complications of prosthetic heart valves. *Mod Concepts Cardiovasc Dis* 48:59, 1979.
9. Cribier A, et al: Percutaneous transluminal aortic valvuloplasty in adult aortic stenosis: Results in 130 patients. *JACC (Abster)*, Feb. 1987, 13A.

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* Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.





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1. Martinez C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.

2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium, San Francisco, October 1987.

OBITUARIES

Robert L. Adair, MD, Hilton Head, SC; Case Western Reserve University School of Medicine, 1943; age 69; died March 13, 1988; member OSMA and AMA.

Lewis H. Bronson, MD, Cleveland; Yale University School of Medicine, New Haven, CT, 1937; age 75; died April 1, 1988; member OSMA and AMA.

Gail W. Busch, Jr., MD, New Carlisle; Medical College of Virginia Commonwealth University School of Medicine, Richmond, VA, 1954; age 63; died January 21, 1988; member OSMA.

Benjamin Caplan, MD, Columbus; University of Toronto Faculty of Medicine, Toronto, Ontario, Canada, 1936; age 76; died March 25, 1988; member OSMA and AMA.

Alfred R. Cukerbaum, MD, Pompano Beach, FL; Ohio State University College of Medicine, 1933; age 80; died March 28, 1988; member OSMA and AMA.

Leo S. Friedman, MD, Cincinnati; University of Cincinnati College of Medicine, 1941; age 89; died April 1, 1988; member OSMA and AMA.

Hart N. Guonjian, MD, Canton; Medical School, American University of Beirut, Beirut, Lebanon, 1937; age 78; died April 11, 1988; member OSMA and AMA.

Harry K. Hines, MD, Cincinnati; University of Cincinnati College of Medicine, 1941; age 75; died April 3, 1988; member OSMA and AMA.

Edward R. Malia, MD, Cleveland; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1950; age 73; died March 20, 1988; member OSMA and AMA.

Howard R. Mitchell, Columbus; Ohio State University College of Medicine, 1923; age 93; died March 8, 1988; member OSMA and AMA.

Frank J. Rowe, MD, Wichita, KS; George Washington University School of Medicine, 1952; age 64; died March 7, 1988; member OSMA and AMA.

Lowell Smith, MD, Chillicothe; Ohio State University College of Medicine, 1948; age 63; died March 23, 1988; member OSMA.

Frank K. Urban, MD, Kettering; University of Cincinnati College of Medicine, 1942; age 71; died April 10, 1988; member OSMA and AMA.

Emmerich von Haam, MD, Columbus; Universitaet Wien, Medizinische Fakultät, Wien, Austria, 1926; age 84; died April 14, 1988; member OSMA and AMA.

**NEXT MONTH
in**

**OHIO
Medicine**

JOURNAL OF THE
OHIO STATE MEDICAL ASSOCIATION

**Issues for the
21st century**

**Can they be resolved
interprofessionally?**

The July issue will examine some of the new (and old) issues medicine will face in the 21st century. We'll also take a look at just how successful medicine might be if it combined its efforts to resolve them.

Recognizing, Minimalizing Loss Awareness

This column initiates a new "Loss Awareness Bulletin" which will be published regularly in *OHIO Medicine* by the Subcommittee on Loss Awareness through the OSMA's Task Force on Professional Liability.

The purpose of this Bulletin is to make Ohio physicians aware of situations which may lead to liability lawsuits. It is not intended to provide legal advice or counsel, nor will the Bulletin attempt to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

The subcommittee gratefully acknowledges the assistance of the Oregon State Medical Association, which has conducted a similar program for many years, in formulating this new member service for the OSMA.

The subcommittee also expresses appreciation to Physicians Insurance Company of Ohio (PICO), the underwriter of the OSMA Group Plan for Medical Professional Liability, which has agreed to assist in future issues of the Bulletin.

Your comments and suggestions for subject matter you feel would be of interest to our membership, will be welcomed.

What is Loss Awareness?

Loss awareness is knowledge, alertness, understanding, logic, common sense and recognition of the patient's feelings and needs . . . including those not necessarily medically-related. Of course, not every unfortunate medical result is

preventable, nor is every unfortunate medical result caused by provider negligence.

Experts agree that what physicians and their staffs do before and after an unfortunate medical result can determine whether it turns into a malpractice claim. Following are four ways to recognize and minimize potential risks before and after the medical service.

1. Patients Are People, Too!

In the broadest sense, the medical office can be seen as a service facility, with physicians offering their training, knowledge and skills to the public.

No matter how brilliant the physician is, and how skilled and well-trained the staff, if the patient does not feel that the doctor and staff care about and understand his or her personal situation and feelings, resentment toward that "office" is likely to build. If there is an unfortunate medical result, the result coupled with the resentment might result in a malpractice claim.

To eliminate negative feelings about your practice, ask yourself and your staff the key question: "Would you be happy if . . . ?" Then modify and change your attitude and conduct.

2. Behind Closed Doors

Be sure your offices provide appropriate patient privacy. Patients have a right to expect that their medical care is a matter of discussion between their physician

and themselves.

Listen to the sounds of your office. Recognize its physical limitations and monitor how sound carries between the examining rooms, the waiting rooms, staff facilities and your private office. Then, modify behaviors accordingly.

3. Hold Your Tongue!

Criticism of another practitioner's care should never be a subject of discussion with a patient by either the physician or the staff. It is not possible to fairly evaluate a patient's previous medical treatment when the only available information is the patient's interpretation of events.

Be aware not only of what you say to patients about their previous care but also how you say it . . . a raised eyebrow or shake of the head can give an opinion as easily as a statement.

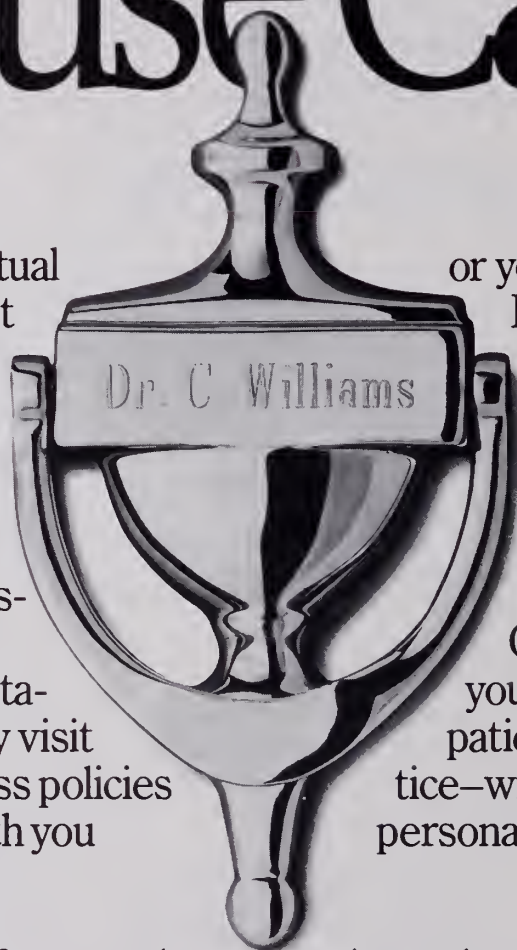
4. Protection Can Be Dangerous

Sometimes, in order to ease the pressure and demands of a busy practice, a doctor's staff will attempt to shield him or her from the day-to-day outside pressures inherent in the practice of medicine. This conduct can be dangerous to your "medical-legal health."

In some circumstances, it is appropriate for the staff to protect a physician from sales representatives, repairers, etc., but the physician should never be isolated from patients.

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The Medical Student Section's Annual Meeting

By Cindy Smith

The OSMA-MSS 1988 annual meeting was held Saturday, February 27 at the Parke Hotel in Columbus. All of the medical schools from Ohio were well represented for an 8 a.m.-to-6 p.m. day filled with reports, new business (of which some items were hotly debated) elections and an address to the assembly by D. Ross Irons, MD.

Just before lunch, the assembly watched a research presentation by a Case Western Reserve student. Three students were given awards of research excellence: Robert Long, John Robinson and Gregory Schnier. The awards and presentation were the culmination of the OSMA-MSS Medical Student Research Colloquium which was initiated at the 1987 OSMA-MSS annual meeting. This research colloquium is expected to grow as more students and faculty in Ohio become aware of it.

The OSMA-MSS considered 17 regular resolutions as well as three late resolutions. Some highlights of the resolutions considered:

4-88 Asks the OSMA to develop and/or support state legislation which addresses the sale, distribution and manufacture of drug paraphernalia.

Action: Passed

6-88 Asks that the AMA-MSS

support the incorporation of practice management skills into undergraduate medical education through appropriate channels.

Action: Passed

7-88 Asks that the OSMA-MSS governing council and staff create a policy handbook

for the OSMA-MSS.

Action: Referred to Council
8-88 Asks the OSMA to ask the AMA to establish ethical guidelines which address the issues of prenatal diagnoses results and organ harvesting.

Continued on page 495



Excellence in Research

The successful OSMA-MSS Medical Student Research Colloquium, initiated last year, produced three award winners this year. Pictured above is Gregory Schnier (center), presented his award by Karen Guss-King, 1987-88 Vice-President OSMA-MSS and Derrick Jeter, Immediate Past President.

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- Action: Passed
- 9-88 Asks the OSMA to support clearly stated parental and sick leave policies in all accredited residency programs.
- Action: Passed
- 10-88 Asks the OSMA to work to develop legislation legalizing living wills and/or durable power of attorney for health care in the state of Ohio.
- Action: Passed
- 12-88 Asks the OSMA to recommend to its members that they continue to donate a minimum of 50 hrs/year to serving the poor.
- Action: Passed
- 13-88 Asks the OSMA-MSS to support the development of extracurricular programs in each school that will facilitate interaction of medical students with people with developmental disabilities.
- Action: Referred to Council
- 14-88 Asks the OSMA-MSS to organize a one-day seminar in Columbus on the topic of Students Teaching Students in the spring of 1988 to share ideas and to allow for better coordination of efforts around the state.
- Action: Referred to Council
- 15-88 Asks that the OSMA-MSS support the creditation of student-to-student community health education projects in other states.
- Action: Passed
- 16-88 Asks the OSMA-MSS to publish the "Ohio Medical Student Bulletin" on a quarterly basis.
- Action: Referred to Council
- It is obvious that Ohio students have been very active this year. The resolutions presented at the OSMA-MSS 1988 annual meeting address many important issues.

The elections this year were exciting with many qualified candidates running.

The officers who will serve as next year's OSMA-MSS leaders are as follows:

Richard Steinman-President
Michael Aruta-Vice President
Christopher Reese-Secretary
Audrey Ludwig-Alternate Delegate

The OSMA-MSS once again has elected leaders who have excellent qualifications and appropriate experience. They are qualified to lead the OSMA-MSS through another exciting and productive year.

A sincere thanks and deep appreciation for a year of excellent leadership goes out from the OSMA-MSS to last year's OSMA-MSS officers. Derrick Jeter, Karen Guss-King and Richard Steinman did an exemplary job of leading the OSMA-MSS while Stephen Gilreath served both the OSMA and the OSMA-MSS well in his duties as alternate delegate.

Cindy J. Smith is a second-year medical student at Wright State University's School of Medicine.

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Myths Are Public Dreams

By Ralph I. Fried, MD

The School of Psychoanalysis has focused our attention on the importance of dreams and dream interpretation. Dreams are a key and a window into the human psyche and a tool for understanding the forces that govern human behavior. The struggle among the Id, the Ego and the Super-Ego, the unpleasant and threatening experiences that we humans repress to a subconscious level, often stream into the conscious mind in the form of dreams and usually in symbolic forms.

Many cultures have transformed these internal feelings into national stories, dramatized through the lives of dieties or superior humans. The stories (myths) of Greece and Rome are well known and have attracted the attention of physicians, poets, artists and writers. Physicians have used these dramas to further their insight into the motivational forces that control human behavior. Since these stories are an externalization of the feelings of individuals, the physician can use this knowledge to better serve his patients. As the gods in the Pantheon of ancient Greece and Rome struggle for

power, expose their aspirations and pursue their amours, they mirror the concealed ambitions of mere mortals.

The hero legend — The story of Prometheus

Prometheus is a leader, a benefactor, a protector and a hero with whom less-endowed men can identify. The Titan brothers, Prometheus and Epimetheus, are commanded by Zeus to create all living things upon the earth. Each animal received a special attribute such as strength, courage, speed or a protective covering, that was to enable it to survive.

The time arrived to give something special to humankind that would make him the "Lord of Creation." Prometheus took a stalk of pithy fennel and ascended to heaven where he ignited the torch at the chariot of Apollo. He returned to earth to give man the gift of fire. The gods were furious and sought retribution against Prometheus, as well as man. With great cunning, the gods created an exquisite woman named Pandora. They sent her to earth bearing a tightly-sealed box and she was admonished that she should not

open the box. Pandora was welcomed by Epimetheus and he ignored warnings from his brother to beware of any gift from the gods. Pandora opened the box and out flew all the ills of the world: toil and suffering, famine, pestilence and war. Only hope remained, the indomitable spirit of man. The punishment of Prometheus was to be chained to a rock where a vulture tore at his liver all day. The liver regenerated over night and in the morning the vulture would return.

The story expresses our longing for a hero, a protector and a kind and helping father, someone with who we can identify. Man is forever attempting to understand the mystery of his universe, the origin of travail and suffering and the meaning of life and death. The theft of fire by Prometheus is expiated by the evils that flew from Pandora's box and man shares the guilt of the Titan.

Oedipus Rex — The drama of Sophocles

The story of Oedipus represents a more universal version of "The Hero Legend." A story of striking similarity occurs in many cultures.

A child is conceived, usually by parents of exalted station. The entire process is impeded by many difficulties, often political considerations. When the child is born, an oracle will make dire predictions for the life of the child. In the Oedipus story, the prediction was that he would kill his father and marry his mother. In the common story, the infant is abandoned to die, either in a field or set adrift on the sea. Humble folk, fishermen or farmers find the baby, adopt him/her and raise the child to adulthood. The child liberates his people from tyranny, becomes a hero-heroine and then proceeds to fulfill the deeds predicted at his birth. A notable exception to this tale is the story of Moses who was adopted by a princess of Egypt.

The classic drama of Oedipus again provides a hero figure, albeit one with feet of clay. The taboos of incest and patricide are made clear in the life of this King of Thebes. Even more important, especially for physicians, is the story of intra-family rivalry. I refer to the romantic attraction of the child to the parent of the opposite sex and the rivalry with the isosexual parent. This occurs more commonly in families where the male child has romantic ideas concerning his mother. He regards his father as a rival for the mother and fears mutilation (castration) by the father. Unless these crosscurrents are successfully resolved, the growth and development of the family may suffer.

Additional information of medical interest is the manner in which Oedipus deals with the facts of his adoption. Perceptive physicians can find matters that will better equip them to care for the adopted children under their care. Many adolescents experience "The Family Romance" wherein adolescents fantasize that they have been adopted and that their birth parents are prominent sports

figures, entertainers or prominent and powerful political figures. For the non-adopted child this is a useful device to help him through the conflicts of this transitional period. In the conflicts with parents he can assign all the good attributes to his fantasized parents and release some of his tensions.

For those children who have been adopted outside of their family the whole matter is no fantasy. The adopted child knows that he really has another set of parents. His task is to fuse the image of the two sets of parents in his own mind or he will be beset by an inner turmoil that begets emotional dysphoria. Some evidence for this is the widely-publicized efforts of adoptees to find their birth parents. This underlines the great need for human beings to IDENTIFY — identify with family, culture, ethnic group and nationality.

Daedalus and Icarus

The story of Daedalus and his son Icarus is a reprise of the ancient and continuing longing of man to free himself from his earthbound existence and to soar to any heights to which his imagination can take him. Daedalus, a gifted artisan, created a set of wings using feathers and attached them to the arms by wax. He made one set for himself and one for Icarus. The father carefully instructed his son to not fly too high, but the exuberant and headstrong young man ignored the warnings. The wax melted from the heat of the sun and Icarus crashed into the sea and drowned. In 1905, the Swiss modernist painter, Paul Klee, again expressed this longing of every man for freedom when he painted his picture "Held Mit Dem Flugel" (Hero With the Wing). The painting is a figure of a man with one wing attached to his right arm; the left arm is held in a sling. Paul Klee is saying, "Man yearns to soar, but his aspirations

are doomed."

Eternal love, eternal life — Eos and Tithoneus

Man is the only animal in the forest who knows he must die. Sigmund Freud believed that a portion of the angst of living was the enduring knowledge of our impending mortality. There are many stories of man seeking eternal life, as with Tithoneus, beloved of Eos, Goddess of the Dawn. Eos petitioned Zeus to grant eternal life to Tithoneus but she neglected to request eternal youth for her lover. Tithoneus lived on and on but his physique grew more fragile and his skin withered. Finally, in desperation, he asked Zeus to free him from his life and the king of the gods metamorphosed Tithoneus into a grasshopper.

Sir William Osler, master clinician and teacher, employed this myth to give us an unforgettable description of diffuse scleroderma. "In the more aggravated form, diffuse scleroderma is one of the most terrible of human ills. Like Tithoneus, to wither slowly and like him to be beaten down and marred and wasted until one is a mummy encased in an ever shrinking and slowly contracting skin of steel. It is a fate not pictured in any tragedy, ancient or modern."

It is of interest to note that the artist Paul Klee who was inspired by the stories of Greek mythology was himself the victim of the disease so eloquently described by Dr. Osler.

These few stories are a paradigm of the mythology, the legends and the folk tales that are found in many cultures and many civilizations. They are an expression and an externalization of the inner feelings of all humans. They reveal his yearning for unobtainable goals and expose the crosscurrents of his psyche.

Continued on page 506

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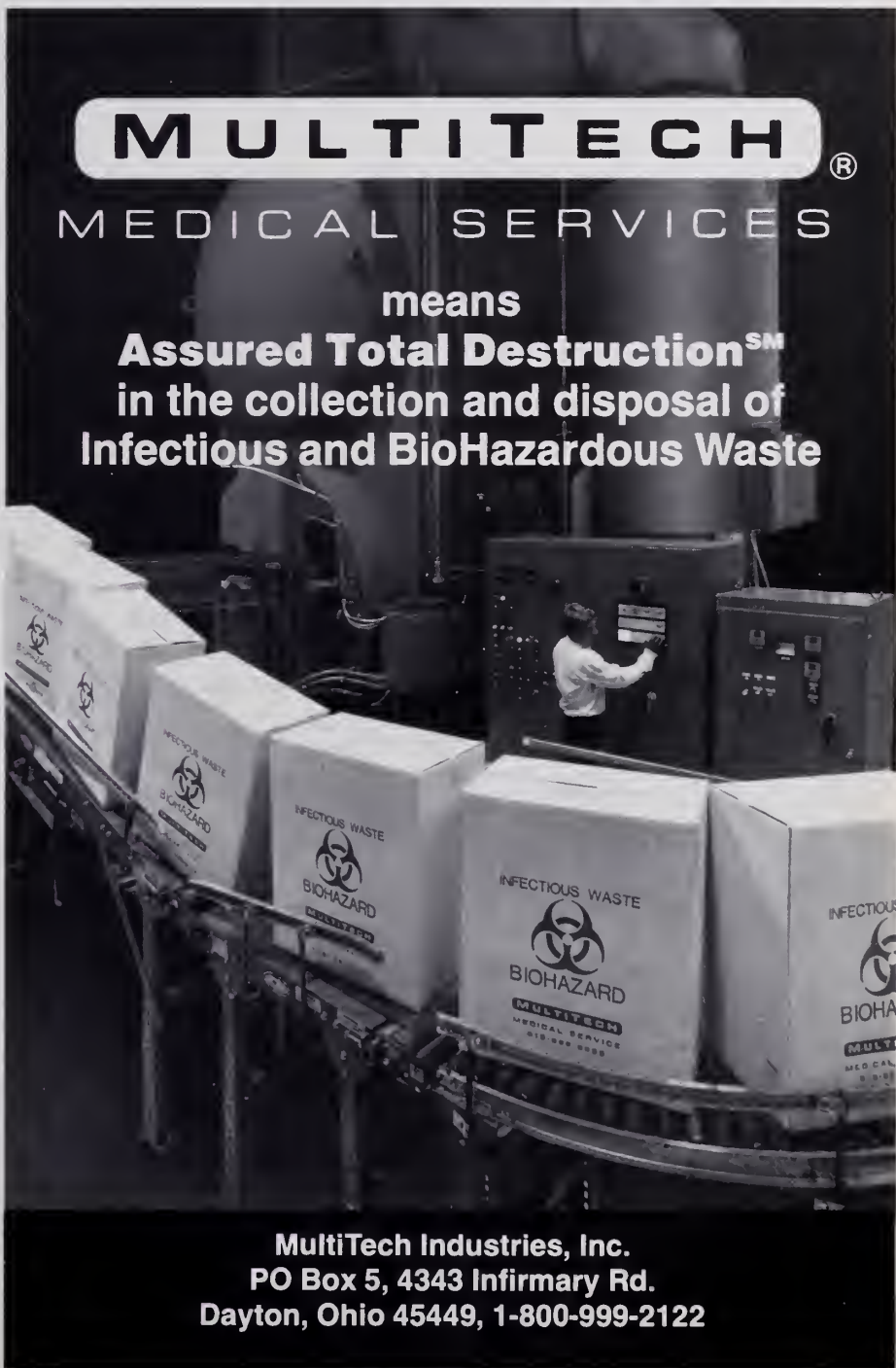
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Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antilindrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlorthalidone, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

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PREVENTION AND MANAGEMENT, July 8-10. **IMPOTENCY: DIAGNOSIS AND MANAGEMENT**, July 15-17. **PULMONARY AND THORACIC DISEASES**, July 22-24. **DIABETES UPDATE** July 29-31. **VENOUS INSUFFICIENCY OF THE LOWER EXTREMITY**, August 5-7. **PHYSICIAN UPDATE ON CANCER, AIDS AND LIVER DISEASE**, August 12-14. **ADVANCES IN CARDIOLOGY**, August 19-21. **LASERS IN MEDICAL PRACTICE**, August 26-28. **NEW ANTI-BIOTICS FOR LIFE THREATENING INFECTIONS**, September 9-11. **INTERVENTIONAL RADIOLOGY**, September 16-18. **ANESTHESIA UPDATE**, September 30-October 2, 1988. For registration and more information call Kathy Saumure (215) 387-3685. **SPEAKERS INCLUDE:** LESTER R. BRYANT, MD, SCD, FACS; RALPH DEPALMA, MD, FACS; MARTIN S. LITWIN, MD, FACS; FREDERICK A. REICHLE, MD, FACS; CHARLES G. ROB, MD, FACS; CHARLES SHUMAN, MD, FACP.

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Ralph I. Fried, MD, is retired and lives in Shaker Heights.

Bibliography

Greek and Roman Myths, Bullfinch; Gods and Heroes, Gustav Schwab; A primer of Freudian Psych., Hall; Need for New Myths, Campbell, Joseph.

AMA Report:

Up-To-Date News from the American Medical Association

Editor's note: This new column will endeavor to keep you informed of various AMA activities, publications and news on a month-to-month basis. Anyone who wishes to contribute information to this column may do so by contacting: Executive Editor, *OHIO Medicine*, 600 South High Street, Columbus, Ohio 43215.

• **AMA Publications...**The American Medical Association has recently developed several publications which are bound to keep you better informed in today's constantly changing socioeconomic climate. Listed below are a few of the newest. You may want to consider ordering yourself a copy or two:

- Puzzled about changes in Medicare, Medicaid and other health-related provisions? This handy, spiral-bound volume specifically summarizes those provisions of OBRA-1987 which affect physicians. Copies of the well-organized booklet are available for \$17 for AMA members; \$20 for non-members. To order, call AMA's toll-free number, 1-800-621-8335. MasterCard and Visa accepted.
- Another new publication, "Policy Research Perspectives," provides authoritative research findings on medical/health news. The first issue addresses statistical flaws inherent in HCFA's hospital mortality data project, which purports to measure quality of hospital care, based on actual and "expected" mortality of Medicare patients. The one-page report concisely presents the issue, discusses how AMA researched the statistical-design issue and presents AMA's research findings. The publication is a service provided by AMA's Center for Health Policy Research. Forthcoming issues will focus on working hours of resident physicians and advertising by physicians. If you would like a complimentary copy of the introductory issue of the publications, contact the AMA Division of Medical Society Relations. Be sure to include your name and mailing address.

• **Growing Membership...**The AMA's Division of Membership reports the following: One of the fastest growing groups of AMA members is osteopathic physicians. Although the total number of osteopaths is small, 2,827 members in 1987, it has nearly doubled since 1984. Year-to-date membership is 2.6% above the same period in 1987 and 102.6% of its year-to-date membership goal. The AMA's 3,152 newest members constitute 46.6% of its year-end membership goal for 1988.

• **Women in Medicine...**The National Center for Health Statistics reports that women are choosing careers in the primary health professions in ever-increasing numbers. The Center's annual report indicates sharp gains in enrollment by women in medical schools since the early 1970s, as well as in schools of dentistry and pharmacy. Since 1971, the proportion of women entering medical school has soared to 33% from 11%. During the same span of time, women edged into the majority of pharmaceutical schools, and comprised 56% of the enrollment during the 1985-86 term. In 1971, only 24% of pharmacy students were women. The most dramatic increases occurred in dentistry where only 1% of students were women during that term. They now comprise one-fourth of classes.

Unless otherwise indicated, contact the AMA by writing: 535 North Dearborn Street, Chicago, IL 60610 or by calling (312) 645-5000

AMA Report: . . . continued

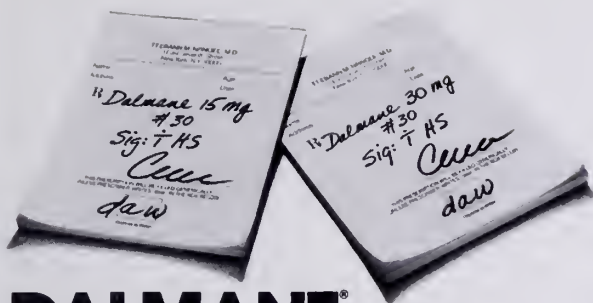
Up-To-Date News from the American Medical Association

• **Making Your Voice Heard...**If you want your voice to be heard in Washington, the AMA has several publications which may be of help.

- A new brochure, "A Guide to Communicating with Members of Congress," has recently been prepared by the AMA and its American Medical Political Action Committee. The suggestions and techniques (including important do's and don'ts) are covered in a pocket-sized, 4 x 9 inch publication, and are equally applicable to elective officials at local, state and national levels. Among the mechanisms covered are letters, mailgrams, telegrams, phone calls, personal visits and group meetings. The publication also contains a glossary of frequently used legislative terms. To obtain a complimentary single copy, contact the AMA's Division of Medical Society Relations. Bulk orders are 15 cents a copy, and may be obtained by writing AMA/AMPAC, 1101 Vermont Ave., NW, Washington, DC 20005.
- "Health Legislative Issues" is a new publication that succinctly describes the AMA's views on dominant federal and state legislative issues. Prepared by the Division of Legislative Activities, the publication provides for each of the issues a brief background, recent legislative and/or other governmental activity and the AMA's position. For a complimentary copy, contact the Division of Legislative Activities.
- The AMA's popular, pocket-sized congressional directory has been updated to reflect "key player" changes that have transpired since the first session of the 100th Congress began. The handy guide lists the members of Congress by their state delegation and by committee assignments and indicates how to contact them. It also provides a helpful index of federal agencies and federal officials, listing their titles, telephone numbers and addresses. In addition, it lists the members of the AMA's Washington Office staff who are responsible for congressional, governmental, and political education liaison. To obtain a copy, contact: Jim Stacey, AMA Washington Office, 1101 Vermont Ave., NW, Washington, DC 20005; (202) 789-7419. The first copy is free, additional copies are \$2 each.

• **Physician Dispensing...**A letter, giving reasons for AMA's opposition to legislation that would severely restrict physician dispensing of prescription drugs, was recently sent to all members of the U.S. Senate. The communication from James H. Sammons, MD, AMA's Executive Vice President, corrected misleading information that has circulated about the AMA's position on this issue.

In outlining the AMA's position, Dr. Sammons stressed the importance of setting the record straight. "The AMA," he said, "believes strongly that there is absolutely no need for federal legislation in this area." Such legislation would be an unwarranted intrusion into an area that traditionally has been the subject of state regulation, he pointed out, "As a general rule," Dr. Sammons continued, "physicians should prescribe and pharmacists should dispense, but with this important caveat: There are situations where physician dispensing is both appropriate and beneficial to the patient. Consequently, the AMA believes emphatically that this prerogative must be preserved."



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References: 1. Kales JD, et al: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A, et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A, et al: *Clin Pharmacol Ther* 19:574-583, May 1976. 4. Kales A, et al: *Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Dement WC, et al: *Behav Med* 5: 25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol* 3:140-150, Apr 1983. 8. Tennant FS, et al: Symposium on the Treatment of Sleep Disorders, teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977.

Before prescribing, please consult complete product information, a summary of which follows:

INDICATIONS: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

CONTRAINDICATIONS: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance at such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

PRECAUTIONS: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function. Inform patients to consult physician before increasing dose or abruptly discontinuing flurazepam HCl.

ADVERSE REACTIONS: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, tinnitus, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

DRUG ABUSE AND DEPENDENCE: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

DOSAGE: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

SUPPLIED: Capsules containing 15 mg or 30 mg flurazepam HCl.

P. 1. 0288

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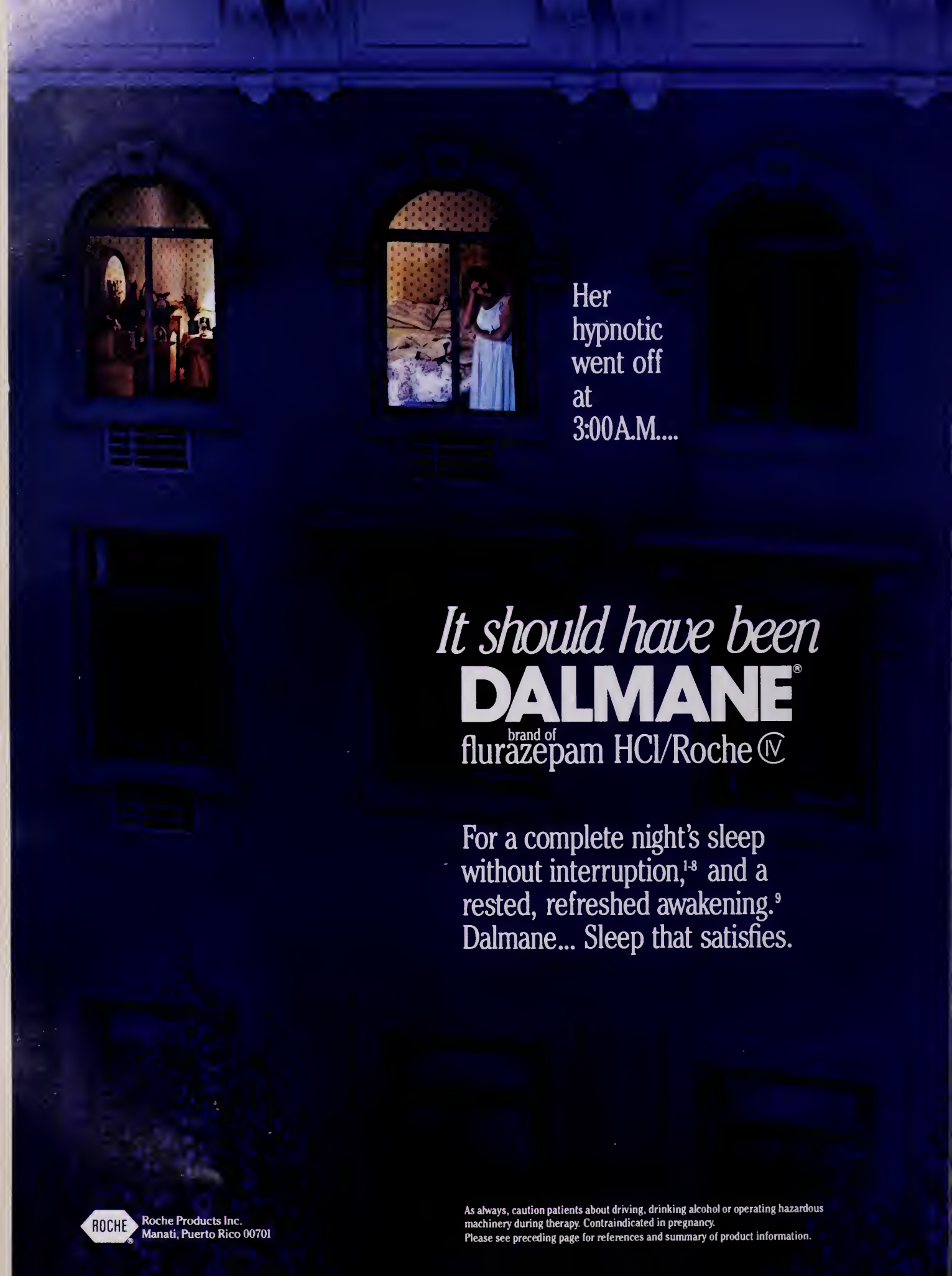


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Please see preceding page for references and summary of product information.

OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 84, NO. 7

JULY, 1988

**Charting
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to an
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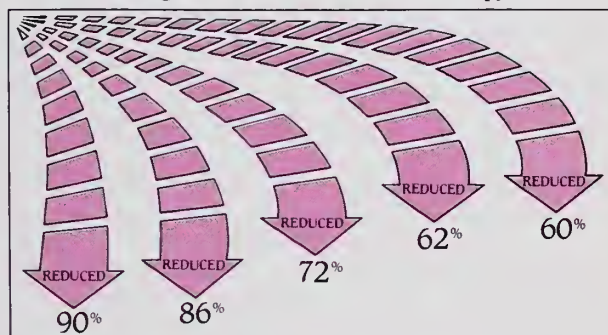
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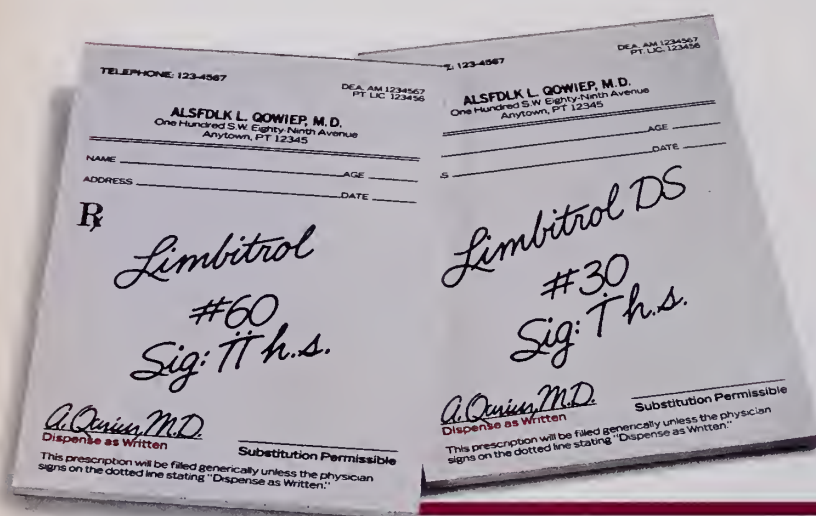
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References: 1. Data on file, Hoffmann-La Roche, Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

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Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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FROM THE EDITOR

Interprofessional Relationships in the 21st Century

As the next century approaches, there is little doubt that issues — medical, social, ethical or moral — will become more complex. We in the 20th century after all, are daily coming to grips with trends and dilemmas that our forebears in the 19th, 18th and 17th centuries couldn't even begin to imagine. Only naturally, then, as we stand on the threshold of yet another hundred-year mark, we'd be foolish *not* to look ahead with a few healthy misgivings, for the problems that yet await us can only be more taxing, more complicated, more demanding.

The only comfort we can derive from all this is that the medical profession is not alone. Other disciplines are experiencing similar difficulties in finding answers and solutions to problems that didn't exist, in some cases, even a year ago.

The issues that medicine will face in the 21st century, then, are not ours alone. They are issues that *all* of the professions will be facing, and somehow attempting to deal with on their own. That's why it makes sense to take a look at how we might be able to work together, interprofessionally, to solve these problems — or at least those in which we have some common bond.

In this issue of *OHIO Medicine*, we take a look at interprofessional relationships . . . at those issues which are likely to arise (or continue with us) into the 21st

century . . . and we look at the possibility of examining those issues on an interprofessional basis. Can it be done? You'll have to read the articles in our special interprofessional section to find out . . .

Also in this issue:

You'll find the final segment of our series on "Aging and Technology" that began with two articles in our June issue. This month, we explore the technology angle, and tell you what is on the horizon today that may just help improve the quality of life for tomorrow's seniors.

You won't want to miss our "Ohio Medi-scene" section this month either. It's full of county medical society news, much of it contributed by the societies themselves. See if your county is mentioned (and if it's not, why don't you write something for us and send it in?).

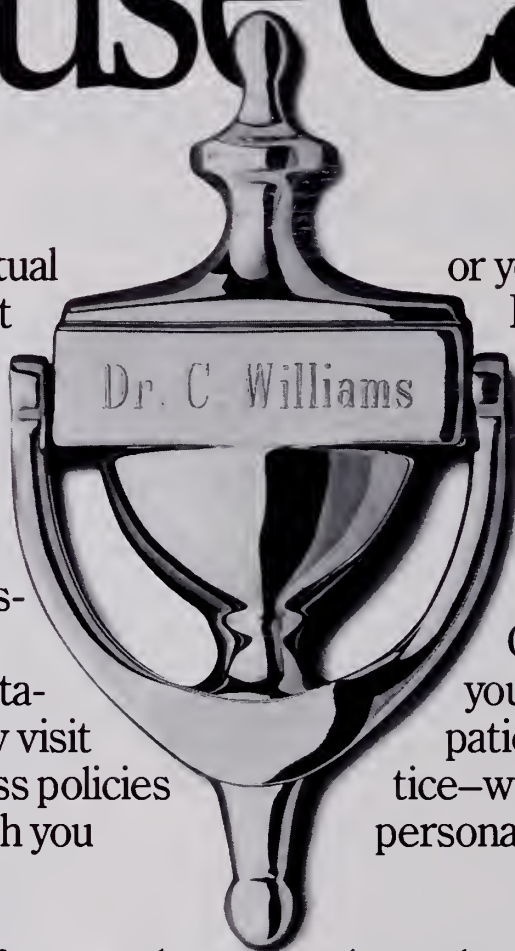
Finally, you'll want to be sure to examine the photos we've included from this year's Annual Meeting. You may just recognize yourself, or someone you know . . .

And that brings us to next month's issue. August will feature all of the Annual Meeting news — from a full report on the resolutions, to the OMPAC Luncheon, to a profile of OSMA's new president. Don't miss it!

Karen S. Edwards

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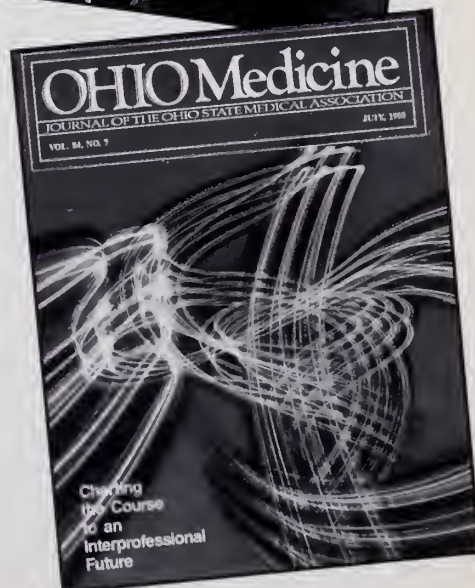
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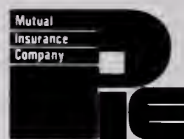
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*By Donavin A. Baumgartner, Jr., MD
President of the OSMA*

Have physicians been too trusting, too “reasonable”?

When physicians communicate with each other, a great deal of trust is involved. This goes beyond facts or opinions related to medicine, to the point that nearly any information between physicians can be considered authentic and reliable. No written confirmation is necessary. Even business matters have traditionally been by handshake. Any written records added by attorneys are rarely even read. We are quite used to our colleagues being open and honest. Unfortunately, this trust of colleagues is too often projected to others who operate on an entirely different set of values and play by a completely different set of rules.

Although medicine is very definitely an art, it is deeply rooted in science. We therefore tend to have the scientist's trust of figures and written materials. Although we have learned to question the validity of figures and opinions in scientific papers, we do

not often carry this over to an intellectual questioning of nonmedical material. We therefore tend to accept as fact such things as insurance printouts, business projections or governmental tables and statistics. Physicians therefore take the entrepreneur at his word and earn the reputation of being poor businessmen. We trust the insurance salesman and the politician with often disastrous consequences. We do not question the individual who will remodel the house or the one providing office equipment, for after all, they are the “experts in that field.”

It has been shown many times in the past that if something is said often enough over a long enough period of time, that it becomes “fact.” Everyone “knows” that all doctors play golf on Wednesdays, that Social Security is a wonderful thing that makes it unnecessary to worry about retirement, and that the best solution to any problem is

federal government involvement. We, as physicians, are susceptible to the same tendencies as the general public in this regard.

An interesting thing happens to one of these accepted “facts” if along with it is attached a value judgment. The question of the basic “fact” being “good” or “bad” becomes an integral part of the original statement. Thus we see the statement “all doctors play golf on Wednesdays so you don’t dare get sick on Wednesdays.” Sometimes the value judgment is implied but the result is the same. If we do not challenge the propaganda, we accept the judgment. A good example of this surfaced several years ago when a spokesman for General Motors was quoted as saying that his company pays more for health care of its employees than it did to U.S. Steel. This statement was immediately altered by many in the news media as well as politicians to: “General

continued on next page

“Who are these authorities that make the pronouncement that spending 10 percent on health care is excessive?”

Motors spends more per car on health care than steel,” an entirely different statement since U.S. Steel was only one part of the steel costs of GM. This false statement received very wide publicity. Even though the profession did catch the error and attempt to set it straight, the correction received very little publicity. Too often we accept these statements and therefore are subjected to the ill effects of the attached implied value judgment.

Many other oft-repeated statements appear regarding health care. We are repeatedly told that we now spend over 10 percent of our gross national product on health care with the expressed or implied comment that this is far too much. Nowhere are the details or sources of this figure easily available for review. No one seems accountable for the details or breakdown of the statistics. No one seems responsible for attesting to the accuracy. Precisely what is included? When we make comparisons with figures of other countries, how are we to assume they refer to the same facts? No one seems concerned that we may well be comparing apples and oranges or looking at statistics reported completely in a different form. Much of what is included in our health-care costs is not included in other countries. Many do not include, for example, any chronic care or nursing home costs, etc. Who are these authorities who make the pronouncement that spending 10 percent on health care is excessive? When they compare our figures with other countries, do they take into account the level or quality of care or do they in fact totally

ignore the presence of far less desirable health-care systems, long waiting lists and rationing of a severe degree that would be totally unacceptable to our population?

Rather than go into a detailed defense of the amount we now spend for health care or even bother to challenge the figure itself, let us just look for a moment to other areas of our economy for comparison. It is clear with a few seconds thought that transportation in this country consumes many times that of health care. In addition, the amount we spend in this country per capita for transportation would dwarf that spent by many other countries where private autos are far less common and air travel is a privilege of a tiny minority. An interesting thing is noted, however, when one attempts to obtain a figure representing the percent of gross national product consumed by transportation. These costs are so widely separated that they are not easily totaled. Take, for example, the costs of air travel. These include not only the price of new airplanes, maintenance and salaries, but ticket sales, advertising, insurance, the cost of running an airport, aviation fuel, food and even the magazines on board, as well as many items one might add if actually delving into the details such as the whole industry related to car rentals and airport transport services ad nauseum. Auto manufacturers, sales, repairs, parts stores, gasoline stations, insurance, car washes, road building and maintenance and even a significant portion of the activities of our police are all part of transportation, and this does not mention the trains, buses,

rapid transit, subways, taxis, parking garages, the manufacture and installation of traffic lights and signs and countless other aspects of daily transportation.

Where are those who cry that we spend too much for health care when it comes to the obscene amounts we spend to get from one place to another? Why should we pay more than the U.S.S.R. or Britain? Where are the cries for reform? Transportation is, of course, largely a necessity of our economy and we must bear the costs as part of our national way of life. Is health care any less necessary or valuable?

In the field of politics, physicians also tend to be trusting and “reasonable.” We understand the political system of developing legislation in that it requires compromise. Therefore, if we propose legislation and know there will be opposition, we tend to be reasonable and *start* with a position that already represents a compromise. We are often appalled at the outrageous stance of our opposition, realizing that no such extreme position could prevail. Even before beginning discussions we therefore modify our stance far toward the opposition as a first point with little or nothing to “give” in the negotiations to follow. We therefore frequently end up with a compromise even less than our bottom line.

It is clear that in order to survive in modern society we must look to our physicians becoming more questioning and, yes, perhaps more militant. Our organization must reflect this attitude. We must demand proof of accusatory statistics or statements. We must

continued on next page

LETTERS TO THE EDITOR

MSS Congrats

To the Editor:

During the previous year the medical student section of the OSMA has worked actively with the OSMA toward the goals of organized medicine. We have been involved in activities which will strengthen the future of all Ohio physicians and medical students. Therefore, on behalf of all Ohio medical students, it gives me great pleasure to publicly congratulate Derrick Jeter (OSMA-MSS President 1987-88), Karen Guss-King (OSMA-MSS Vice President 1987-88) and Stephen Gilreath (AMA Alternate Delegate) on an excellent job which will surely serve as a model to all who follow.

I would also like to congratulate the 1988-89 MSS officers (Michael Aruta, OSMA-MSS Vice President-Elect; Chris Reese, OSMA-MSS Secretary-Elect; and Audrey Ludwig, AMA Alternate Delegate-Elect) upon their election and admonish them to follow in the footsteps of those we follow.

Also, throughout this previous year the medical student section of the OSMA has worked actively with *OHIO Medicine* to keep all Ohio physicians and medical students informed of the activities of organized medicine. Therefore,

it gives me great pleasure to publicly congratulate Cindy Smith upon being appointed Editor in Chief of *Pulse*, the AMA-MSS monthly magazine for 1988-89.

We look forward to another productive year for *OHIO Medicine*, *Pulse*, and all of Ohio's physicians and medical students.

Sincerely yours,

Richard Steinman

OSMA-MSS President-Elect
Sylvania

Preventable Trauma Deaths . . . a Response

To the Editor:

I am grateful to Ohio Medicine for the opportunity to respond to editorials about the preventable death study published in the January, 1988 issue. These letters have questioned the exclusion of head-injured patients from the study (Dr. White), the incidence of preventable deaths in Level I trauma centers (Dr. Luzzi), and the relevance of the study to the current state of trauma care in Columbus (Dr. Schlanger).

I agree with Dr. White that
continued on page 589

Corrections

The article "AIDS Education: Medical Students Respond" by Jonathan C. Reeser (*OHIO Medicine*, Vol. 84, No. 5, May, 1988) ran with a misprint. The sentence on page 382 which began, "For this reason . . ." and concludes with ". . . have a duty to become involved in the right to halt the AIDS epidemic" should have read ". . . have a duty to become involved in the *fight* to halt the AIDS epidemic." *OHIO Medicine* regrets the error.

In the "Letters to the Editor" section in the May, 1988 issue of *OHIO Medicine*, Robert M. Zollinger, MD was listed as a coauthor of a letter written by Olga Jonasson, MD. Dr. Zollinger was not the letter's coauthor, and cannot be held accountable for the opinions expressed in it. The signature should have read "Olga Jonasson, MD, Robert M. Zollinger Professor and Chairman, the Department of Surgery, Ohio State University College of Medicine." *OHIO Medicine* regrets any confusion this error may have caused.

President's Page . . . continued

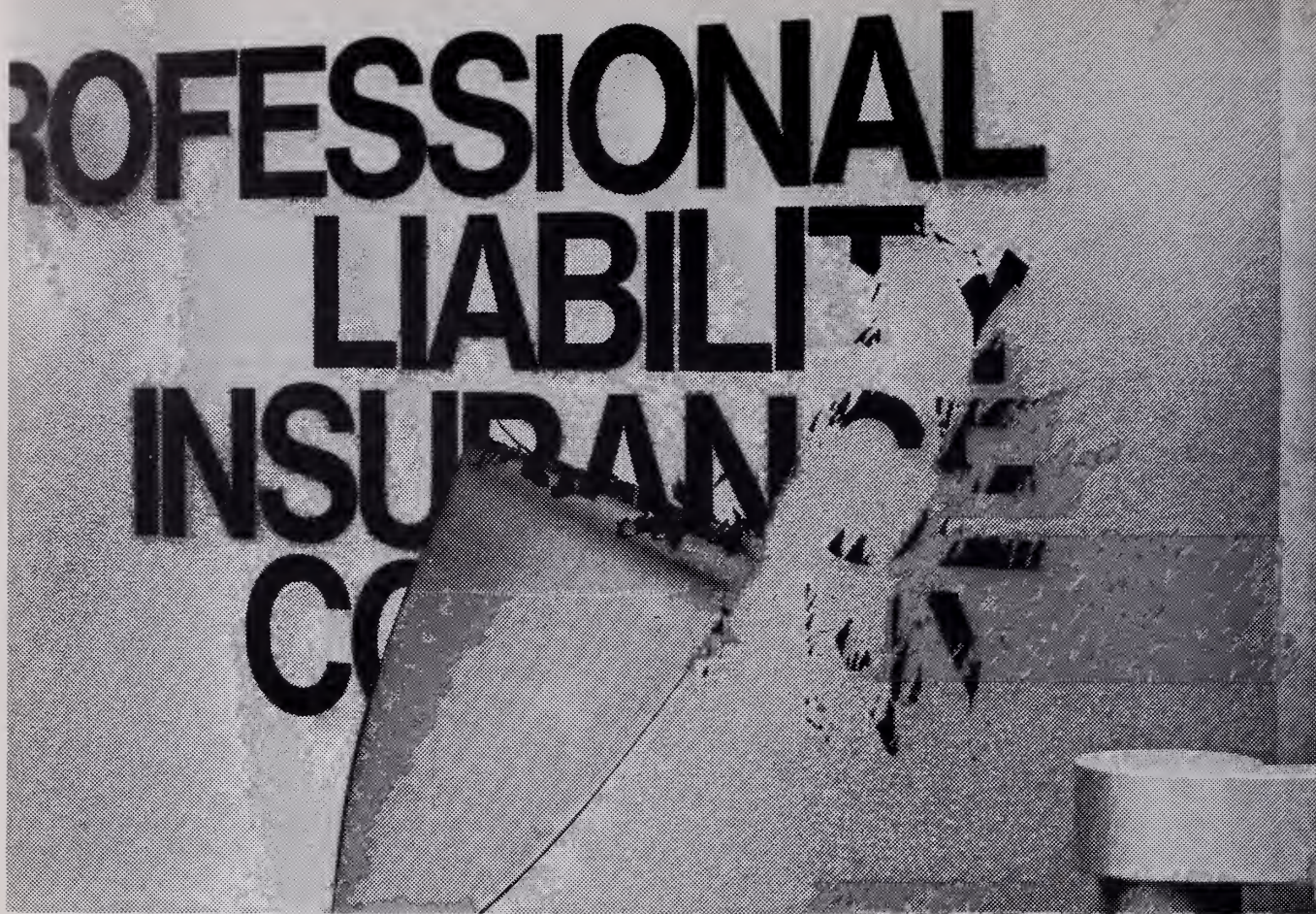
resist changes in governmental programs even more vigorously if they are not in the interest of our patients. This may mean that we must abandon more of the scientific ventures by the federation organizations compared to such activities in the past. This is as it should be, however, as there are many other organizations such as the specialty societies that are very capable of carrying out the educational activities. Obviously, we must not abandon completely the reputation for the voice of

reason that we have developed over the years, but we must not be too quick to accept statistics or promises (remember that Congress included in the Medicare law the promise not to interfere with the practice of medicine!), and we must be more wary of our initial position when approaching negotiations with government, third-party payors and others.

It is therefore submitted that physicians have been too trusting and too reasonable in the past. It will be interesting to see if we can

continue this within the profession, but learn from past mistakes and begin to promote a more careful and prudent approach to life outside the practice of medicine. This may not be easy and certainly involves a change in our traditional behavior, yet it seems a necessity for survival in the present age. With conscious attention to this approach, the federation can be even more responsive to the needs of its members and also serve our patients. **OSMA**

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The Stendhal Syndrome

Hyperkulturemia

By Ralph I. Fried, MD

Marie Henri Beyle (1783-1842), a.k.a. Stendhal, author of *The Charterhouse of Parma*, *Le Rouge et le Noir* and other books, was the first intellectual traveler to record the existence of a symptom cluster now known as the Stendhal Syndrome. While traveling in Italy in 1817, he visited the tombs of great Italian artists in the church of Sante Croce. He developed tachycardia, vertigo and muscular weakness, all symptoms induced by his exposure to great creative artists. He recorded that he recovered by reading some soothing poetry.

In 1904, Sigmund Freud traveled to Athens and was emotionally overcome with the beauties of Ancient Greece, in particular the Parthenon. While on the Acropolis he felt a sense of alienation, guilt, anxiety and panic. His interpretation was that he felt guilt that his father had never had the opportunity to have this great pleasure. Freud named the symptoms that he endured "entfremdungsgefühl."

In a recent article in the *Wall Street Journal*, Brigid Grauman reported on the observations of

Dr. Graziella Magherini and her team from the Ospedale Santa Maria Nuovo of Florence, Italy. Dr. Magherini is a psychiatrist who has seen 107 cases of the Stendhal Syndrome. This concentration of cases is probably due to the concentration of great art in Florence and the number of aficionados who seek it out. She cites the example of a young woman tourist in the city of Cosimo de Medici, who was seized with a crippling terror in front of Michelangelo's "David" and had to be admitted to the hospital.

Dr. Magherini also reports that travelers are found wandering in the streets unable to recall their names. Other findings of the team indicated that underlying this illness was an impressionable personality, the stress of travel and overexposure to the masters of creativity. The gender difference was not significant, and although the Florentine team originally thought that the incidence was greater in tourists from those countries with a less extensive tradition of art, eg. the U.S.A., Australia, New Zealand, an unexpected finding was that European tourists were afflicted

more often than their counterparts from the New World. The greatest number of cases was found in the age group 20-40 years. One may theorize that the urge to travel is a continuation of the childhood urge to explore and discover. In fact, all affected tourists suffer from a form of gluttony, the need to consume the art and take it home with them.

It is my wish to report on a mini-epidemic of the Stendhal Syndrome which I personally encountered. My wife and I joined a group that traveled to Germany with the single purpose of viewing contemporary German art. Every minute of every one of the 18 days was spent either in museums, galleries, artists' ateliers or visiting homes with extensive private collections. I was the least afflicted of the group because I excused myself several times to pursue other interests. As this very intense program continued, the onset of symptoms began in an insidious manner. The first signs were irritability and hostility expressed in personal relations. Confusion, disorientation and selective amnesia appeared as well as some

continued on next page

Stendhal Syndrome . . . continued

somatic symptoms such as dysentery, cephalgia, vertigo and unstable gait. As the tempo of "art viewing" increased, panic reactions occurred.

The planned climax of the tour was to take place in the ancient German city of Kassel. An art show is mounted every five years in Kassel to present the newest, most progressive and the most radical art created by international artists. The artists often use this forum to protest against the evils of 20th century living. The exhibition was very crowded and quite raucous. There were enormous numbers of works and all of this challenged one's senses. Fortunately there was a spa in

Kassel and some members of the group, who felt overwhelmed by so much art, found solace in the unisex hot tubs and saunas.

At this point, the members of the tour exhibited some symptoms, such as nausea or abdominal pain, disorientation, loss of identity and amnesia of space and time. The most serious problem of all was that all of the art was beginning to look exactly alike. No one required hospitalization and it is my belief that nice hotels and gracious hospitality (plus the excellent food and wine) minimized the overt signs and symptoms of the Stendhal Syndrome.

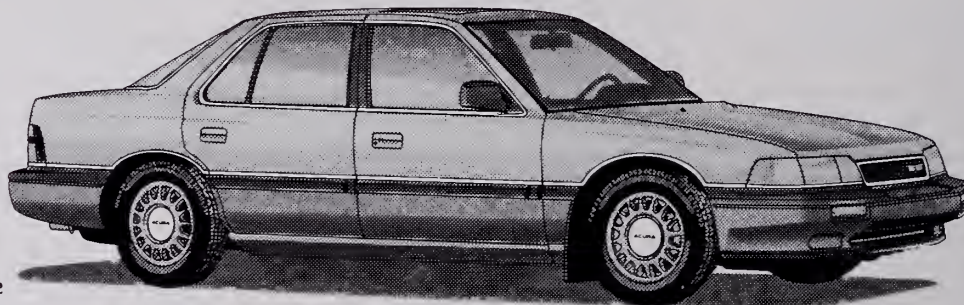
Travel is gaining in popularity each year, especially foreign travel,

and there is a trend toward "theme tours" — architectural, gardens, theater and music tours. In a music tour for example, where the traveler has a steady exposure to opera, symphony and chamber music, the same symptoms might be triggered. We must not forget CME tours with which we are bombarded each day. *Any* form of culture and education which is both concentrated and intense may cause Stendhal and we physicians must be alert.

Ralph I. Fried, MD, is a retired pediatrician living in Cleveland.

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

Retin-A and pregnancy



While Retin-A, the cream that reputedly reduces wrinkling in facial skin, is a product used largely by older women, physicians are urged to remind their pregnant patients to avoid the cream until after delivery.

"There's no drug that's safe, absolutely, to take in pregnancy," says Jay Iams, MD, director of prenatal diagnosis at Ohio State University in a recent article in the *Columbus Dispatch*.

High doses of vitamin A are known to cause birth defects and both Retin-A and Accutane, which is reported to have caused hundreds of birth defects, contain an active ingredient which is the chemical analog of vitamin A.

Although animal studies have shown no birth defects associated with Retin-A, caution is still urged during pregnancy.

Steroids and mind games

Steroids are creating more than just physical problems for athletes who insist on using these artificial means to pump up muscles. Now, the nation's psychiatrists say that steroids may be causing psychiatric problems as well.

In a study of 41 steroid-using athletes, one-third of the group developed major psychiatric complications, ranging from mania to major depression to psychosis — but only during periods of steroid use.

The report, published in the *American Journal of Psychiatry*, described athletes hearing voices, developing paranoid or grandiose delusions in which state they believed nothing could harm them. One athlete, for example, drove a



car into a tree at 40 mph while a friend videotaped the event.

Ironically, all of the athletes studied reported being "very concerned" with maintaining good health — and showed low rates of both alcohol and tobacco abuse.

The expert witness — under scrutiny

Expert witnesses are being carefully examined by states that are hoping to limit the number of malpractice lawsuits brought to trial by limiting the number of those who qualify as "expert witnesses."

Alabama, for example, recently set up the following standards for that state's expert witnesses. The expert witness must:

- be licensed
- be trained and experienced in the same specialty as the defendant
- have practiced the same discipline as the defendant during the year preceding the alleged act of malpractice
- be certified by an appropriate American board, in the same specialty as the defendant (if the

defendant is certified)

Kansas, Maryland, Michigan, Rhode Island, West Virginia and Connecticut have all recently set up similar standards for their state's expert witnesses.

Iowa, which passed standards in 1986, is now considering tightening them — so that expert witnesses would be required to spend at least half of their time in practice, or teaching subjects related to the one at issue.

Such laws could put "hired guns" out of business, says Arthur Kaufman, MD, vice-president of Forensic Medical Advisory service, Washington, D.C. in a recent issue of *Hospitals*. "But they won't hurt reputable physicians or businesses."

New cancer treatment available in Ohio

Bethesda Oak Hospital in Cincinnati announces that it will begin treating cancer patients with the controversial biotherapy technique which uses the patient's own white blood cells, combined with interleukin-2, to create "killer" cells which, in some cases, shrink or stop the tumor's growth.

Cost of the treatment is typically \$19,000 — a high price, critics say, for an experimental treatment that they believe works no better than surgery, radiation or chemotherapy. Bethesda, however, plans to set aside a portion of the fees paid to create a fund for patients who can't afford the treatment, but who are good candidates for it.

Eight patients will be accommodated in the program which is divided into two phases. The first is the biotherapy treatment, given by a continuous intravenous drip, lasting 15 days. The second phase is a tumor preservation program in which a patient's tumor is kept as a source of white blood cells, to be used in later treatments.

Bethesda is accepting only patients whose cancers are not readily treatable with standard therapies, or those for whom standard treatment has failed. Patients must also be in good health (beyond the cancer), as the treatment has potentially toxic side effects, including sudden drops in blood pressure, severe chills, nausea, anemia and fatigue. Generally, only 15 percent of those who apply are accepted.

Results from the National Cancer Institute indicate that 20 percent of patients who are in a biotherapy program benefit from the treatment — about the same success as those patients in a chemotherapy program.

Headaches — a genetic disease

Which one comes first . . . the stress or the headache?

According to Joel Saper, MD, director of the Michigan Headache and Neurological Institute in Ann Arbor, stress has very little to do with headaches . . . at least those painful, recurring ones that seem to spring from nowhere.

Dr. Saper believes instead that headaches are a genetic disease — not a psychological one — although certain things can make them better or worse.

Over-the-counter painkillers, for example, can aggravate a recurring headache, he says — "like

scratching a rash." So, too, can such factors as diet, smoking, alcohol — even sleep patterns.

Yet, while the chronic headache can be controlled with proper advice and medication, it cannot be completely cured.

"Medical science, historically, believes that which we don't understand is psychological," he says, but he remains convinced, after years of researching and treating headaches that, "It is clear there is a genetic trait toward headaches — just as there is toward such diseases as diabetes, epilepsy or alcoholism."



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Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks. Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix* may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established. **Use in Elderly Patients**—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to

Axid* (nizatidine, Lilly)

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

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OHIO MEDI-SCENE

Diagnosing and treating Kaposi's sarcoma . . . a healthy exchange . . . young scientist awards . . . a new use for lasers . . . the AIDS IQ . . . a nationwide AIDS survey . . . PICO awards . . . student-to-student program . . .

Diagnosing, treating AIDS-related Kaposi's sarcoma

Classically, Kaposi's sarcoma appears in men of Mediterranean background, responds well to treatment and rarely is there any mucosal or nodal involvement. If any case of KS appears differently, suspect AIDS, says Richard Schulof, MD, an oncologist and principle investigator studying new treatments for the AIDS virus at George Washington University in Washington, D.C. Dr. Schulof recently spoke on the subject of Kaposi's sarcoma and current research and treatment of AIDS at Riverside Hospital in Columbus.

During the early 1980s, Kaposi's sarcoma was the single most common presenting complaint among AIDS patients in the gay population, but that is changing now, says Dr. Schulof. According to recent statistics, KS currently appears in 10 percent or fewer of the cases involving gay male AIDS patients (pneumocystis carinii accounts for 65 percent of the cases reported and the incidence of AIDS-related lymphoma is increasing so rapidly, Dr. Schulof predicts it may soon overtake the number of cases of KS). Still, KS is a disease that seems to be exclusive to

gay men, he says, pointing out that in all of his studies of hemophiliac AIDS patients, none has ever presented with Kaposi's sarcoma.

"Which indicates to me there must be a co-factor with the disease," he comments.

Initially, patients, with AIDS-related KS will present with gastrointestinal complaints ("They're so common, I don't do a GI tract workup anymore," he says) and/or oral lesions will appear on other parts of the body — commonly on the upper and lower eyelid, the end of the nose, inside the ear or in the ear's outer canal, and, as already mentioned, in the oral cavity. Gum involvement is also typical.

"Patients are pretty good at picking up their own lesions," Dr. Schulof comments. "They show them to me."

But KS is an easy diagnosis to make — even without patient help. Besides the telltale lesions, KS, under the microscope, will appear as spindle-shaped cells — "though they can look benign," warns Dr. Schulof.

"And, like syphilis, KS can present radiographically in many different ways," he adds.

X-rays of a lung, liver and bowel,

projected for those at the meeting, distinctly showed what Dr. Schulof refers to as KS's "patchy involvement" with these organs.

Sero-monitoring is a new, somewhat controversial technique that is also proving helpful, says Dr. Schulof — not in diagnosing KS per se, but in determining the presence of the AIDS virus. A positive serum P24 antigen test puts the patient in a high-risk group — but don't expect to find the antigen unless the patient has just contracted the disease or is in the latent stage of the virus, he cautions, since the antigen appears briefly at the onset, disappears and reappears in the later stages. Sero-monitoring is especially useful, however, if HIV is suspected and the ELISA test comes back with a false-negative. "Order a P24, and if the P24 comes back positive, make your diagnosis," he says, adding that despite the controversy, "I would recommend sero-monitoring for now."

But while diagnosing KS may be relatively easy, determining a prognosis for KS patients is not.

"Ninety percent of the patients with KS do not die from the sarcoma itself, but from other opportunistic

OHIO MEDI-SCENE

Kaposi's sarcoma . . . continued

infections they may have or acquire," Dr. Schulof says, which is what makes KS so difficult to treat.

"In treating Kaposi's sarcoma — don't treat it unless it is disseminating," he says, warning that if the sarcoma is treated too soon, the treatment may lead to a life-threatening situation.

"KS is typically a cosmetic, not a life-threatening problem," he points out. Despite this, however, the prognosis for patients with AIDS-related KS is rarely over two years — less if there is an opportunistic infection involved.

"In that case, the prognosis is usually six to nine months," Dr. Schulof says.

Treatment, however, can help, depending on the stage of the disease. Dr. Schulof says the staging definition developed by the University of California at Los Angeles is the one now used most frequently. Stage I refers to

Schulof.

Laboratory evaluation is also helpful in determining a prognosis, he continues. For example, in those cases where the helper T-cell count is above 100, the prognosis is generally good; below 100 the prognosis is poor. A low hematocrit will also mean a poor prognosis.

If the KS is localized, however, treatment can be effective. Dr. Schulof recommends both surgical excision and low-dose radiation therapy which, in the right cases, has proven remarkably successful, he reports. If the KS has disseminated, but is indolent, he recommends immunotherapy or single-agent chemotherapy. "These patients will do well with interferon," he reports. In those cases where the KS is aggressively disseminating, creating a life-threatening situation, then combination chemotherapy may be tried.

Presently, trial combinations of

tinues. He recommends a daily dose of 10 million units, and says "push as high as you can get." Often, interferon is combined with AZT and more recently with a third drug — GM-CSF — to combat the less aggressive cases of Kaposi's sarcoma. But interferon is not without its toxicity.

"The principle reason for dose-limiting interferon is the flu-like syndrome it brings on," says Dr. Schulof.

While the syndrome does go away after a few weeks, it is apt to leave the patient with an anorexic-type of weakness, "so you can't dose for long periods of time," Dr. Schulof cautions.

Also, because response time for interferon is two to three months, patients with opportunistic infections often have no chance to respond to the drug.

"If it's an aggressive, life-threatening case, treat the patient with low-dose chemotherapy once a week. If it's a less aggressive case, you have the option of using a single or double-agent chemotherapy or an interferon combination," he sums up.

The problem with any systemic treatment, however, is that it is difficult to achieve complete remission. There is usually a short duration of response, and maintenance therapy is always necessary, he adds.

"Nevertheless, we have made inroads in the last five years. Patients with KS do tolerate therapy with appropriate treatment, and can go on to lead a relatively good existence," Dr. Schulof concludes. — *Karen S. Edwards*

"Ninety percent of KS patients don't die from KS itself, but from other opportunistic infections."

patients with 10 lesions or fewer; stage II to patient's with greater than 10 lesions; stage III to cases of KS which show visceral involvement; and stage IV to cases exhibiting cutaneous and visceral or pulmonary involvement.

Patients in stages I and III of the disease have a better prognosis than those in stages II and IV, where dissemination has taken place, says Dr.

three drugs are given to patients in these life-threatening situations, and regression can be seen in about 70 percent of the cases. "But though the response rate is good, patients will generally develop other opportunistic infections," he cautions.

Candidates who are eligible for alpha interferon therapy will do well with high doses, Dr. Schulof con-



A healthy exchange: Cleveland physicians on the line

This past spring, the Academy of Medicine of Cleveland and local television station WEWS presented the second "Health Exchange" television program. During the live, two-hour broadcast, a panel of 25 Academy physicians answered telephone calls from the public on a variety of health concerns. As was the case with the first "Health Exchange" program last year, the physicians took more than 1,200 calls (between 50 and 60 each).

As part of the show, hosts Wilma Smith, WEWS news anchor, and Ted Castele, MD, WEWS medical editor, spoke with Wilma F. Bergfeld, MD, president of the Academy of Medicine, at the beginning and end of the program. They also interviewed medical experts in several areas. These included breast cancer, with Carolyn Lee, MD, Carmen Paradis, MD, and Robert Waltz, MD; cholesterol, good and bad, with Herman Hellerstein, MD; stress and its complications, with Richard Christie, MD; protecting your child, with Donald Barich, MD, and Pamala Murphy, MD; and sleep disorders, with David Hudgel, MD.

The idea for this program came from the Academy of Medicine's Public Relations Committee, which is chaired by Frederick T. Suppes, MD. Dr. Castele, also a member of the Public Relations Committee, pitched the idea to WEWS station management. Dr. Castele is director of radiology at Lutheran Medical Center in Cleveland and chairman of the Ohio delegation to the American Medical Association.

Again this year, the "Health Exchange" was a great success, and brought a great deal of feedback and goodwill to the Academy of Medi-

cine. Future programs are planned. — *Alex J. Koleszar*, Public Relations Assistant, The Academy of Medicine of Cleveland

OSMA awards young scientists

Marcus M. Yamashiro of Maumee, Ohio, a 12th-grade student at St. John's High School, Toledo, was named by the OSMA's judging team as winner of the Association's top award during the 40th Annual State Science Day held this past spring at Ohio Wesleyan University, Delaware, Ohio.

Yamashiro's exhibit was entitled "Yeast Killer Toxins in the Pichia-Williopsis Group." He will receive from the OSMA a large, hand-lettered plaque and a \$100 U.S. Savings Bond.

The OSMA judging team also named five grade-level winners as follows:

7th Grade — Matt D. Hepp, Wapakoneta, Ohio (St. Joseph Elementary School), "The Effects of Testosterone on the Metabolism of Chicks."

8th Grade — Josh T. Mendell, Worthington, Ohio (McCord Middle School), "Alterations in DNA by Environmental Influences."

9th Grade — Joe P. Rich, Cincinnati, Ohio (Purcell Marian High School), "Fish Oil vs. Cholesterol."

10th Grade — Mark J. Olsen, Worthington, Ohio (Worthington High School), "Melanin: The Key to Melanoma."

11th Grade — Rolf N. Barth, Upper Arlington, Ohio (Upper Arlington High School), "Cryogenic Storage of Epithelial Tissue."

The five grade winners will receive framed certificates from the OSMA.

This marked the seventh consecutive year that the OSMA has sponsored State Science Day awards. The event is sponsored by the Ohio Junior Academy of Science, a branch of the Ohio Academy of Science.

D. James Hickson, MD, of Mt. Gilead is chairman of the OSMA judging team. Vice-chairman is Melanie S. Kennedy, MD, of Columbus.

Other physicians serving on the 1988 judging team were Elizabeth R. Aplin, MD, Columbus; James Bazoli, MD, Marion; Charles E. Casto, MD, Stow; Dennis M. Doody, MD, Columbus; Susan Hubbell, MD, Lima; Leonard J. Janchar, MD, Marion; John McFadden, MD, Cuyahoga Falls; Charles B. Reiner, MD, Delaware; Delphis C. Richardson, MD, Columbus; Thomas E. Shaffer, MD, Columbus; William G. Wasson, MD, Canton; Judy Westman, MD, Columbus; and David L. Zwick, MD, Columbus. — *Robert D. Clinger*



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55	1457.50	1377.50	2870.00	2675.00	4277.50	3985.00	5665.00	5295.00
FEMALE NONSMOKER RATES								
Age	\$250,000		\$500,000		\$750,000		\$1,000,000	
	Std.	Select	Std.	Select	Std.	Select	Std.	Select
35	\$ 290.00	\$ 235.00	\$ 535.00	\$ 425.00	\$ 775.00	\$ 610.00	\$ 995.00	\$ 795.00
45	595.00	452.50	1145.00	845.00	1690.00	1232.50	2215.00	1625.00
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OHIO MEDI-SCENE

A new use for lasers

No one would dispute the fact that incredible strides have been made in the field of lasers; since their development in 1960, dozens, if not hundreds, of new applications for the devices have been discovered and refined. And now, the latest case in point: The use of lasers during breast cancer surgery, an option that is currently being offered at University Hospitals in Cleveland.

The technology allowing lasers to be used during such surgery has actually been around for at least five years, says Joseph P. Crowe, MD, a surgeon at the hospital's Ireland Cancer Center, but up until fairly recently, the procedure has been used infrequently.

"The last couple of years, (lasers) have been used with greater frequency (in breast cancer surgery)," Dr. Crowe says, adding that as laser equipment becomes more common in more hospitals, so too will the procedure. "Had you asked me a couple of years ago, I would've said four or five hospitals (were offering the procedure) . . . but now surgeons are becoming more experienced with laser surgery."

There are several reasons a surgeon may choose to use a laser over the more traditional scalpel. "First, it's a very precise way to do the surgery," Dr. Crowe explains, adding that lasers also allow access to hard-to-see areas, cause less trauma to surrounding tissues and organs, and cut and seal blood vessels all in one step.

The decision to use a laser for breast cancer surgery, he continues, is



Lasers allow access to hard-to-reach areas, cause less tissue trauma, and cut and seal blood vessels in one step.

not so dependent upon the patient as it is upon the skill of the surgeon performing the operation.

"Actually, laser surgery is a technique," Dr. Crowe explains. "It just aids the surgeon. I think it's not so much dependent on the patient . . . it seems it's more helpful for the surgeon in terms of large tumors and large cancers."

Although laser breast surgery takes about the same amount of time as conventional surgery — approximately two hours — recovery *may* be quicker in some circumstances since the laser minimizes tissue damage.

"We've noticed (laser surgery) is at least as good as what we've been doing," Dr. Crowe notes. "It's sort of patient-dependent, but most patients

heal very nicely with few complications."

Since the Ireland Cancer Center began offering the procedure a year ago, Dr. Crowe estimates that about 150-200 operations have been performed. However, he warns, those figures should not suggest that the procedure is common or widely available.

"Most of the bigger teaching hospitals in Ohio are doing breast surgery with lasers," Dr. Crowe says. However, he adds, most smaller hospitals don't offer the procedure because they are unable to afford the cost of laser equipment.

"It's certainly more expensive initially for the equipment," Dr. Crowe says. "It's going to take awhile for it to become cost-effective."

Another reason the procedure is relatively uncommon: Few physicians are adequately trained in laser surgery.

"There's a primitive use of lasers right now," Dr. Crowe says, referring to the level of technology. Current lasers are rather cumbersome, he says, and may discourage physicians from becoming trained in their operation.

However, Dr. Crowe predicts, as technology improves and laser surgery becomes more accepted, laser surgery in general will become more widespread.

"I think that eventually, (lasers) are going to become more available to the surgeon who right now may not have access to one."

— Michelle J. Carlson

OHIO MEDI-SCENE

Tallying the AIDS IQ

And the answer is: *Granulocytopenia and anemia.*

For *Jeopardy* fans, this style of brain-picking is probably familiar. And considering society's penchant for quizzes, questionnaires and the like, it's of small surprise that tests and surveys about AIDS are popping up around the country.

Most of these AIDS surveys so far deal primarily with physicians' attitudes about the disease: Would they treat a patient with AIDS? Do they favor mandatory testing of particular groups?

But newer is the trend toward surveys that measure physician knowledge about the disease — AIDS IQ tests, in a way.

One such test appeared in the April '88 issue of *California Physician*. Because of the technical nature of some of the questions, they might even have stumped *Jeopardy*-lord Alex Trebek. (Borrowed from that survey is the question that prompted the answer in the first sentence of this article: "What is the most severe side effect from zidovudine?")

But other surveys are designed to tally the knowledge about AIDS among a variety of groups, including physicians, nurses, parents and teachers. One such survey has been developed by three Youngstown professionals: Francine Glista, community health education youth coordinator, and John Venglarcik, MD, director of infectious pediatric disease, both of Tod Children's Hospital; and Mark Kittleson, a health instructor at Youngstown State University.

"We sat down and devised a survey that could establish an information base about AIDS," explains Dr.

Venglarcik. To date, approximately 250 individuals have taken the survey. And, while the data is still in preliminary stages, he says some interesting patterns are beginning to emerge.

"It has become apparent that some of the problems people are having (with AIDS) is in dealing with the sexuality issue," he says.

The survey includes a sequence of questions about routes of transmission, sexual practices and sexually transmitted diseases. These areas tended to cause the most uncertainty among the respondents, Dr. Venglarcik says.

What we found, he continues, is that physicians do well on the basic facts about AIDS — statistics, testing

and history. But in general, "Physicians had more difficulty dealing with sex-related issues of their patients and sexual counseling."

Dr. Venglarcik attributes this finding to the fact that most older physicians did not have the human sexuality courses that are now a part of today's medical curriculum. "It's not just (that physicians have) a conservative view . . . but some do not have the knowledge base in sexual issues."

This may explain why residents scored the highest of all those who took the survey. Residents share a similar medical background with attending physicians, but have also taken courses in sexuality, he points

continued on next page

Physicians respond to nationwide AIDS survey

The majority (69%) of physicians polled by *Physician Management* magazine report that they would treat AIDS or ARC patients in their practice; 13% said they would not; and 18% were undecided.

Of the 456 physicians who responded to the survey, 43% said they had encountered AIDS or ARC in their practice.

The propensity to treat AIDS patients corresponded with age, according to survey results: 95% of those age 30 and under and 80% of the physicians between 30 and 39 say they would treat an AIDS patient. This willingness drops to 54% for doctors age 50 to 59, and 49% for those over 60.

The survey suggested that physicians age 60 and older are also less likely to treat HIV-positive patients than their younger counterparts.

In another area of the survey, 64% of physician respondents report that they favor some kind of mandatory testing for AIDS. Fifty-four percent believe marriage license applicants should be tested; 82% of the respondents report that prostitutes and drug addicts should be tested; 27% say nurses should be tested; and 22% say physicians themselves should be tested.

A favorable finding of the survey is that over 60% of physicians say they have attended two or more continuing education lectures about AIDS.

out. Attending physicians finished immediately after residents in the survey, and then other health-care professionals, teachers, and finally, parents.

One reason parents don't do as well is because they rely on magazines and TV for most of their health information, which can often be fragmented and incomplete, he says.

The survey also revealed that the range of knowledge about AIDS among teachers varied extensively. "There is a real need for physicians and the community to make sure that teachers have the facts (about AIDS)," he points out.

The survey was distributed to Youngstown area teachers before and after a seminar on AIDS. The teachers showed marked improvement after the AIDS session, Dr. Venglarcik says. The pre-test results indicated a somewhat fragmented understanding of the disease.

"This survey is one way to compare and contrast the variety of knowledge in health-care workers and to assess their knowledge," he says. Once we uncover the gaps in their knowledge, we can try to patch them up.

Dr. Venglarcik and others plan to submit an abstract on their findings to a conference of health educators in the fall. They also want to distribute the survey to rural physicians for a less hospital-based response.

Others in the Ohio medical community are also looking into the value of AIDS surveys. Leonard Calabrese, DO, of the Cleveland Clinic, is reportedly surveying participants in his AIDS seminars for their attitudes about and comprehension of the disease.

"The assumption is that physicians know all there is to know (about AIDS). And it's reassuring to know," Dr. Venglarcik says, "that they do know a great deal."

But there may still be some uncertainties about the disease lingering in the public and the medical community, he says. And by asking the right questions, we may be able to provide the right answers. — *Deborah Athy*

Medical students receive 1988 PICO Awards

Renee Sue Domanico, of the Northeastern Ohio Universities College of Medicine, Tamyra L. Mouginis, of Case Western Reserve University's School of Medicine, and David Applegate II, of The Ohio State University College of Medicine, have been selected as 1988 PICO Award recipients.

A major provider of professional liability coverage for medical professionals, Physicians Insurance Company of Ohio established the PICO Award Program in 1979 to recognize graduating students in Ohio medical schools for furthering excellence in physician/patient relations.

Renee Sue Domanico of North Canton has been active in numerous groups and organizations while attending Northeastern Ohio Universities, including the Student Aid and Awards Committee, the Orientation Committee, the Graduation Committee, and the Women in Medicine

Reading Group. She also serves as a student assistant in the Office of Student Affairs, and as a peer adviser. Dr. Domanico has accepted a pediatric residency with the University of Chicago Medical Center.

Tamyra L. Mouginis of Cleveland has been recognized by Case Western Reserve University for receiving honors evaluations during several clerkships in medicine and surgery. Dr. Mouginis will remain in her home area to pursue internal medicine at Case Western Reserve University Hospitals.

David Applegate II of Columbus was recognized by the faculty of the Ohio State University Department of Pediatrics for his excellent patient care, his compassion for his patients and his dedication to medicine. Dr. Applegate will pursue a residency in family medicine at Riverside Methodist Hospital in Columbus.

Columbus Academy promotes student-to-student program

The Ohio State Medical Association and the Academy of Medicine of Columbus and Franklin County jointly sponsored a program initiated by the OSMA Medical Student Section (OSMA-MSS), which provides elementary, junior high and high schools (both public and private) with medical student speakers on a variety of health-related topics.

Medical students from the Ohio State University College of Medicine prepared to speak on topics including:

1. The Human Heart
2. The Dangers of Smoking
3. The Dangers of Drug and Alcohol Abuse
4. How to Become a Medical Doctor

The medical students' efforts to educate the youth in our community reached 20 schools and over 1,000 students on the medical consequences of smoking and alcohol/drug abuse.

Program coordinator Mary Riess

The program reached over 1,000 students on the effects of smoking, alcohol and drugs.

effectively monitored the central Ohio project. Students Walter Klatt and Courtney Roberts coordinated the smoking program. In addition to their efforts, 11

continued on next page

OHIO MEDI-SCENE

Student-to-student . . . continued

OSU College of Medicine students volunteered their time in speaking to 15 schools regarding the dangers of smoking. Participating students include: Nandita Bhattacharjee, Jonathon Reeser, David Fryman, Andy Stein, Harriet Jakob, Christine Katona, Laurie Donahue, Noel Williams, Kathleen Quealy, Bill Groucett and Dave Sybert.

Nasir Suleiman served as lead coordinator for the Alcohol presentations. He and fellow medical students, Kristen Earle, Lance Talmadge and Mark Wert delivered the presentation to five Columbus area schools.

The 1988-89 program will include a presentation on "AIDS — Facts and Fiction."

In addition to the smoking and alcohol programs, presentations were also prepared by medical students Stephanie Sadlor and Laura Wypasek on "The Human Heart" and "Becoming a Doctor."

The Student-to-Student program will be repeated for Columbus area schools during the 1988-89 year with the addition of a presentation entitled "AIDS — Facts and Fiction." Medical students who are interested in participating in the program should contact the Academy of Medicine at 766-6221.

Pam Porter, Academy of Medicine of Columbus and Franklin County.



An OSU medical student leads a classroom discussion as part of the continuing student-to-student program.

COLLEAGUES IN THE NEWS

THADDEUS M. BORT, MD, Mainesville, has been appointed medical director of the Village Health Care Center in Cincinnati . . . **W. THOMAS JACKSON, MD**, Toledo, has been named chairman and professor of the Department of Orthopedic Surgery at the Medical College of Ohio . . . **HOWARD A. WERMAN, MD**, Columbus, has been named medical director of SKYMED, the aero-medical helicopter service operated by Ohio State University Hospitals . . . **JAMES I. TENNENBAUM, MD**, Columbus, has been elected to the Board of Regents of the American College of Allergists . . . **WILMA BERGFELD, MD**, a Cleveland dermatologist, has been named a trendsetter by *New Cleveland Woman*

magazine . . . **ANDREW J. MANGANARO, MD**, Dayton, has been named medical chief of staff at Greene Memorial Hospital in Xenia . . . **Z. CHARLES FIXLER, MD**, a Cincinnati dermatologist, has been named president of the medical staff at Drake Memorial Hospital . . . **THOMAS PANKE, MD**, Cincinnati, has been named director of Pathology and Laboratory Medicine at Good Samaritan Hospital . . . **BEN YAMAGUCHI, MD**, Ripley, has been honored with the Vytautas Karoblis, MD, Commemorative Award for Meritorious Service by Brown County General Hospital . . . **PHILIP BALIN, MD**, Cleveland, has been elected vice president of the American Society for Dermatologic Surgery.

The 1988 OSMA Annual Meeting Highlights



D. Ross Irons, MD, presides at the 1988 House of Delegates.



Donavin A. Baumgartner, Jr., MD, assumes the office of OSMA president.

*Watch for the complete Annual Meeting
roundup in the August OHIO Medicine!*

Day 1



Physicians receive Membership Outreach information at the First Session of the House of Delegates.



Oscar W. Clarke, MD, receives a Distinguished Service Award from Thomas W. Morgan, MD, as his wife Susan looks on.



A picture of the new OSMA headquarters, located at 1500 Lake Shore Drive, was included in the Annual Meeting slide show.



The Young Physicians Committee, including chairman Victoria Ruff, MD, meet to discuss issues and set goals.



OMPAC Chairman Jerome Kimmelman, MD, (center) presents the first OMPAC Distinguished Service Awards to Rose Vesper and A. Burton Payne, MD, at the OMPAC luncheon.

Day 3



The head table of the OSMA House of Delegates.



William J. Marshall, MD, addresses the house after his election as OSMA President-Elect.

The Installation of Donavin A. Baumgartner, Jr., MD



Past president John Albers, MD, installs Donavin A. Baumgartner, Jr., MD as OSMA's new president.



Dr. Baumgartner, his wife Marilyn, and their family.



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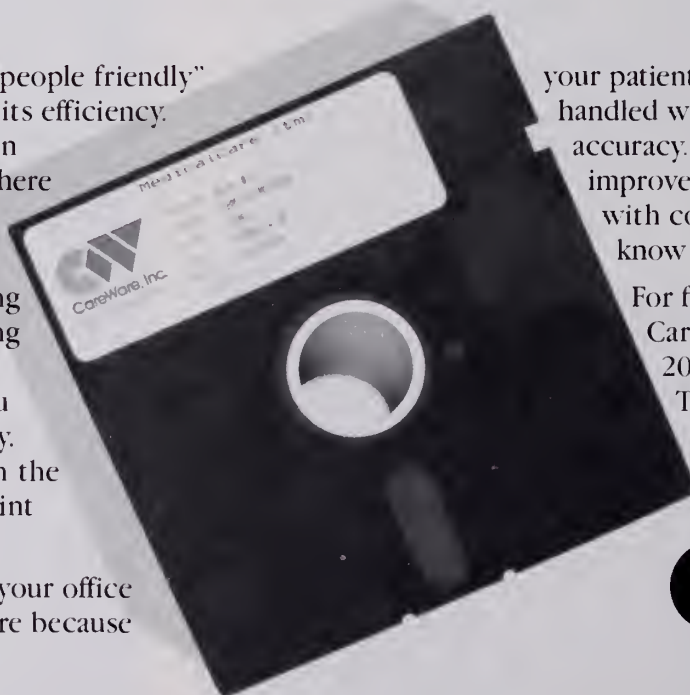
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*A variety of issues will face the professionals of the 21st century . . .
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Tomorrow's Professionals:

Who Are They and How Will They Cope?

Technology may be changing and improving the quality of man's existence — but that's not the only thing it's changing, says Thomas H. Walz, a professor in the School of Social Work at the University of Iowa and the keynote speaker at the recent interprofessional conference on "Issues for the 21st Century," sponsored by Ohio State University's Commission on Interprofessional Education and Practice.

According to Walz, the "high-tech paradigm" that has evolved over the past 40 years has been responsible for producing most of this country's social change as well — reshaping its institutions to fit its own means and ends. Swiftly, he enumerates examples:

"First, there is the marketplace, our economy, which has become very high-tech and global," he says. This has created a powerful driving force in society — but along with it has come a growing welfare state as well — "a natural complement to a high-tech world," Walz philosophizes.

Medicine, too, has felt the changes brought on by a technology that "industrializes and corporatizes" as it goes.

"High technology attracts capitalists," he says, and it is these business-focused individuals, he continues, who have altered the health-care system, corporatizing it into national and international structures which have affected, and will continue to affect, access to health-care services.

And who will there be in the future to handle these problems created by such rapid change? What kind of professional is developing along with our high-tech society?

Walz states that writers today are posing a number of general theories about how the brave new professions of tomorrow will develop.

There are those, for example, who believe that all professions go through different stages in their development.

"Originally, they say, the professions begin as legitimate, fulfilling a need, helping others. But given enough time, there is goal displacement, and the professions become self-serving. It's referred to as the 'second

By Karen S. Edwards

watershed' and there are writers who believe that is where America is now," Walz says.

Others feel that the professions are stratifying themselves into a hierarchy — a new "technocracy" — where those who are closely aligned with scientific and technological research move into an elite inner circle, leaving the practicing clinician on the outer fringes, scrambling for status as well as funds.

Then there is the theory known as "institutional parenting," in which the values and ethics of the institutions that are rapidly evolving in our society become the model for the professions.

"Over time, functions that have traditionally been held by families have been contracted out to institutional 'parents.' These institutions have identified a need in the marketplace and expanded to meet that need," explains Walz.

In this theory, the professionals become more like entrepreneurs, always looking for new markets to serve — as well as ways to invest their attendant wealth.

Of course, how close any of these developmental theories will come to reality is a guess at best — but Walz has identified three "power centers," i.e., current structures that may well play an influential role in the future development of the professions.

The first of these power centers, he says, is an active, professional accrediting body — most of which have assumed, by now, lives of their own.

"These professional organizations will have a lot to do with how their professions look in the future," says Walz.

However, he sees "meritocracy" as remaining a constant in all the professions.

"There is no end to the amount of continuing education that is needed by those in the professions," Walz insists. This

trend, in fact, is likely to escalate into a "non-terminal" degree for the professional of the future.

"The end will always be kept open — there will always be another certificate to achieve," he says.

"In fact, lately," he adds, "it's become a bit of a game — a dynamic of the association — but since certification requirements can always be justified, they will continue to be demanded of the professions."

He doubts, however, that professional boards or associations will control the number of admissions into the professions . . . or into their appropriate certification programs.

The principle of supply and demand will continue to shape the professions in the future.

"They hate to control the growth of their own profession," he says. "They may know they are training too many (professionals) — a good example is the lawyers — but they just can't quit."

There may be, however, an effort to increase the growth of the scientific-based professional practice, as opposed to the clinical or more practical base, he says.

As a result, the professions may begin to see fewer and fewer interns — those who learn the trade from hands-on experience — and more and more research assistants "who can help in the pursuit of a scholarly enterprise," says Walz, adding that the shape of each profession will be influenced by this, since such sheer scientific training will not only academize the new professionals, but put them under a new stress to

research, discover and publish as well.

"We're already beginning to see signs of this," he warns, citing as an example an attorney he knows. "He's teaching — but he has no real clinical experience in law. He has never actually tried a case through the courts."

A second power-base Walz believes is likely to influence the development of the professions in the future is the federal government — and the power it commands through its federal funds.

"There is no doubt that bureaucracy appears in the professions, and that it helps to shape them," he says.

Sometimes, for example, government will step into an area of professional study when it appears that no one else will.

"Geriatric development, for example, did not come from the AMA but from the federal government," claims Walz, and the same holds true, he says, for the area of the aging developmentally-disabled.

"That's when the government stepped in," he says.

But just as quickly as government will jump *into* a project — it is just as capable of beating a hasty retreat.

Walz points to the government's speedy exit from medical education as an example.

"The minute they learned of the perceived oversupply of doctors, and realized they might be adding to that, they left the field abruptly," he says.

Yet the principle of supply and demand — with or without government assistance — will be another factor that continues to shape the professions in the future, Walz emphasizes.

"Doctors are already protecting their volume of patients," he points out. "And they don't refer

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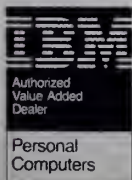
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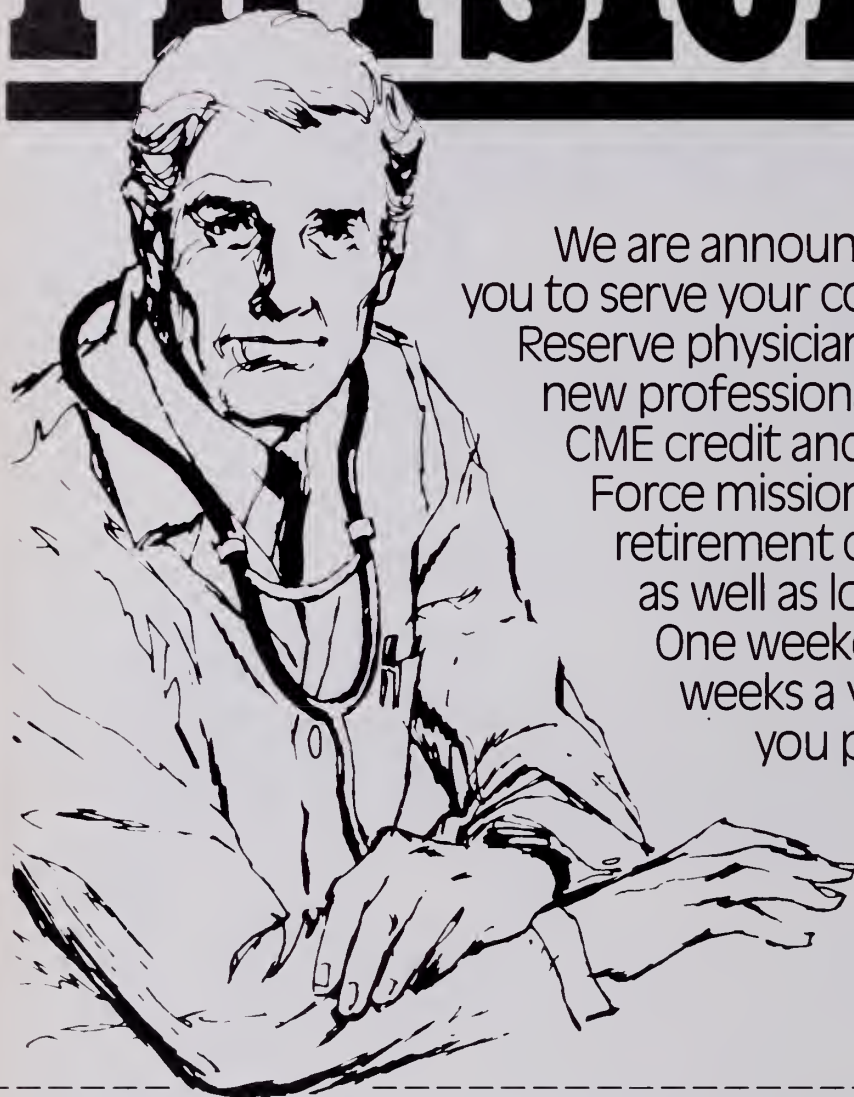


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patients as frequently as they once did — they're a little cooler toward each other."

As a result, we will see medicine beginning to make some gradual changes in the future, he says.

"Those doctors who are in traditional practices will go into HMOs; nurses will look to expand their roles and status by developing into nurse practitioners; and young physicians, without a patient base and little chance of getting any referrals, will begin to compete for jobs formerly held by nurses," he predicts.

But any oversupply is short lived. Already the number of high school students applying to colleges and the number of college students applying to professional schools is down, he notes.

What this might mean, however, is that the professions will start to recruit its members from other countries — especially if those recruits are research-proficient.

The move away from surgical solutions to medical problems is another behavior-shaping trend that is likely to influence the shape of the health-care industry, specifically in the future.

"We'll see hospitals move from acute-care facilities to intensive care facilities, and we'll see the expansion of long-term care facilities," Walz predicts.

The third power-base that may alter the professions in the future is the changing university environment.

"These days, the president of a university can be equated to a corporate chief executive officer," Walz states — and, of course, like any good CEO, these presidents naturally favor those professions where the money lies.

"If a profession has enough technology to attract dollars from industry and the government, then it will be elevated at the university level. If it is a low-technology profession, it will be re-ranked and

pushed toward the university's margins — in danger of extinction."

He points to the area of home economics as an example.

"Unless it is a highly-specialized, technological area like nutrition, it's disappearing from the university."

As a result of all these changes, he continues, the motivational profile of those who are entering the professions is beginning to alter.

"In social work, we are starting to see more middle-class women launching second careers, and their daughters who are launching their first. These women, we've learned, want to help people — but not all people. They just want to work with those who are like them — they're not anxious to work with different social classes."

He tells, also, of an associate dean of medical students who has begun to note a similar situation occurring at medical school.

"He said that those who are now opting for a career in medicine are attracted to the profession by its high technology. They want to play with the gadgets. Generally, they have a strong math or science background, and they believe medicine is a good place for this. But they are not necessarily oriented toward patients," he says.

What will these changes mean for the future, then? A cold, technocratic world, where machines become more important than people? If that is, indeed, the direction in which the professions seem to be heading, could a strong, interprofessional relationship help to restore a balance — as a sense of humanity — back into the society from which it is being so quickly excised?

Maybe, says Walz, but there are definitely some roadblocks that must somehow be surmounted

before any type of interprofessional relationship can get off the ground.

First is the prohibitive cost of delivering health care in an interprofessional manner.

"The classic example is the team management situation in a long-term care facility," says Walz. "By the time everyone has met and reviewed the charts and made recommendations, care has already become expensive. The cost of down time in these situations is ridiculous."

And turf wars — as well as natural differences — between the professions may continue to hamper quality interdisciplinary work, he points out.

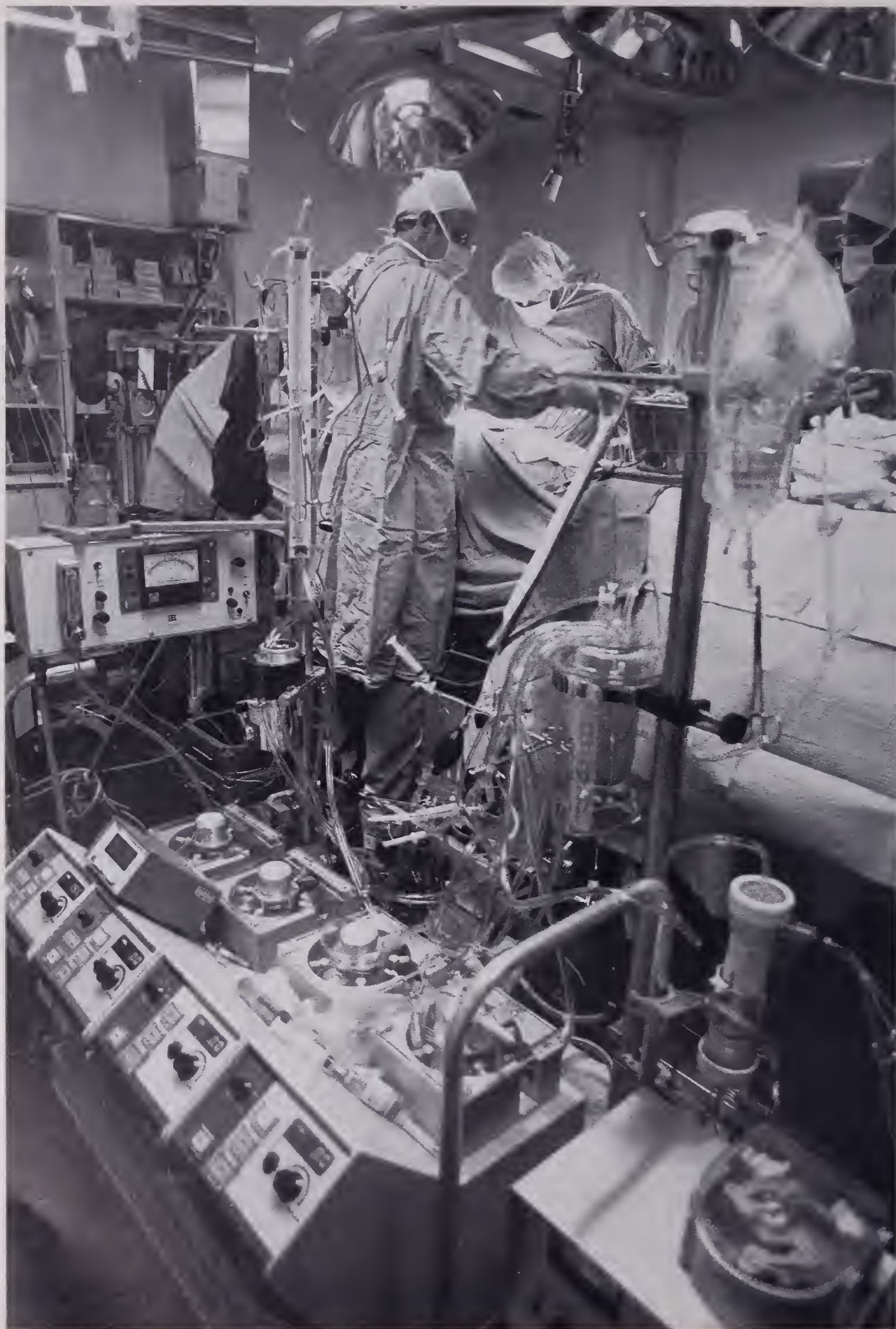
"Some professions are so specialized they have their own language and theory base — and those simply don't translate well to the other professions," he says — like the three pharmacists who tried to conduct a workshop Walz recently attended on drugs and how they interact with nutrients.

"The three spoke in such technical jargon, they were only understandable to each other," he comments. "By the time it came around to asking questions, no one in the audience could pose a single one. Here they thought they had communicated all of this information to us, and of course, they had communicated nothing at all."

Perhaps, he adds, before the professions can work together successfully, a common language will be needed.

Still another roadblock facing interprofessional development, Walz continues, is the fact that interdisciplinary studies are rarely conducted at the university level — making such teamwork difficult to nurture and support outside of the learning environment.

"We have survived by our specialization," says Walz. "That's
continued on page 592



Courtesy of St. Vincent's Hospital, Toledo.

“Sold to the Highest Bidder!”:

The Rationing of Health Care

By Michelle J. Carlson

It's no secret that health-care services — from routine examinations to major operations — cost more these days. It's also no secret that, more often than not, indigent patients aren't usually privy to the latest, high-tech — read more expensive — procedures such as kidney dialysis and organ transplants as are their more affluent, *insured* counterparts.

And, if industry projections are correct — and there's little reason to doubt their accuracy — health-care costs will continue to escalate well into the 21st century, as will the problems associated with allocating health-care resources equally among the nation's population.

Unless, says David Jackson, MD, a professor of preventive medicine at the Ohio State University and former Director of the Ohio Department of Health, we consider the problem now, and make a genuine effort to plan for the future.

Dr. Jackson was on hand recently to address participants of a workshop entitled “Allocation of

Health-Care Resources,” held during an interprofessional conference sponsored by Ohio State.

“We have paradoxes (in the health-care system) that can't be answered by any one profession,” Dr. Jackson began. “For example, we can't afford to provide prenatal care to every woman in the country, but we can talk about building a superconducting collider.

“The goals of macro-allocation,” he continued, “are to set up a template to check against. We have to ask ourselves, Is the distribution fair? Is there access? Is the process understood, not only by professionals, but by the people receiving the services? Are there financial barriers to those services?” Answering these questions, he stressed, is essential when addressing the issue of equal allocation of health-care services.

Early indications

Unfortunately, the practice of rationing health care is not a new

one. Indeed, according to Dr. Jackson, health-care professionals were first faced with such a situation in Seattle in the early 1960s. There a major breakthrough in the field of renal dialysis was made and six dialysis machines were made available. The problem, Dr. Jackson said, was that six machines could not possibly serve all of the patients requiring dialysis, so a group that came to be known as the “God Committee” was formed to determine which patients merited dialysis the most — a committee that, in effect, tried to play God by deciding whose life was worth more than another's.

“I personally think there are fairer ways to allocate resources,” Dr. Jackson said of the incident. “The first time we were faced with rationing, we ducked the issue.” But if nothing else came of that early test, one thing became evident: It would not be the last. Or, as Dr. Jackson pointed out, “Now we find ourselves rationing every day.”

continued on next page

The plot thickens

A more recent lesson in proper allocation of resources, Dr. Jackson noted, has been learned since the development and refinement of the heart transplant — an incredibly expensive operation, he said, that can cost well over \$70,000, not to mention the average annual bill of \$10,000 to cover the cost of continuing medication.

The trouble began, Dr. Jackson said, almost as soon as the technology became available and the heart transplant became a viable option for certain cardiac patients. “We saw sales of organs to foreign nationals (and) hospitals that wouldn’t put you on the (transplant) waiting list unless you had \$100,000 ready for the transplant,” he said, pausing to tell the story of one man who had at least that much money in various holdings, who was told to liquidate his assets before he would be considered for a transplant. “To me,” Dr. Jackson said, shaking his head, “that’s unconscionable.”

But the competition to secure scarce organs doesn’t end with hearts. Said Dr. Jackson: “The most grievous case occurred when a child from Texas, who had no insurance . . . was given a liver after a plea was made by the president. No one ever asked if the patient had the most potential for transplant. No one ever thought that what we were actually waiting for was the death of another child.”

In what he called “the biggest issue I’ve ever encountered professionally,” Dr. Jackson relayed a similar story. At the hospital where he was practicing at the time, an active alcoholic was being considered for a liver transplant. When a liver became available, the team of physicians was faced with a serious dilemma: Without a new liver, the patient

had a poor chance of survival. On the other hand, to use a scarce organ for transplant in a patient who was still abusing alcohol — the primary contributor to his liver disease — was to deny another patient with a better prognosis a chance at life.

The doctors’ decision? “We refused to do the transplant until the patient had gone through an alcohol recovery program,” Dr.

that there are limited resources — without question,” she observed, which prompted Dr. Jackson to comment that “perhaps we have accepted some economic policies that are not true.” (i.e., the Medicare system is in a state of decay while the government continues to spend millions, if not billions, of dollars on national defense.)

Ransome Williams, MD,

“I think technology has created these ethical issues . . . but the pure benefits of technology by far overwhelms the issues.”

Jackson said, adding that that is the kind of responsible, ethical decision-making that is all too often ignored.

The problems the rationing of health care has created are numerous and complex, Dr. Jackson said, yet they should not be blamed solely on the medical community. “These are the kinds of issues where interprofessional input can make a difference,” he said, adding that it will take a varied group of people — from medical, theological, educational and administrative disciplines — to tackle and ultimately answer two central questions: Are health-care resources *truly* scarce, and how do we ensure that those available resources are allocated fairly?

Missiles or medicine?

As the workshop participants split into two groups and eagerly began to explore the issue of rationing, it became apparent that Dr. Jackson’s opening remarks had had quite an impact.

Carole A. Anderson, Dean of the College of Nursing at Ohio State, was the first to address his concerns. “Professionals have bought into that assumption —

Director of Grant Family Practice Center, Grant Medical Center, took the argument one step further. “Are these funds available? Are there resources available? They are if we eliminate some of the things that drain our resources.

“If (national) security is a basic goal, that’s all well and good,” he continued, “but you have to ask what it is you’re securing, what it is you’re protecting” if a nation doesn’t have enough resources to keep its population alive and healthy.

An eye on ethics

Since it’s highly unlikely that the government will reverse its current policies in order to pump money into the health-care system, most medical professionals are resigned to accept that their resources are limited. If that is the case then, how do *you* decide who gets what? By a patient’s ability to pay? By the degree of his sickness? By his age? Have you ever even thought about *how* such decisions are made? If you’re like most in the medical community, chances are you haven’t.

“Only lately have I become

acutely aware of how allocation of resources is a front issue," Dr. Williams admitted. "Ethics is at the base of (the issue) and I regret a lack of attention to it."

Anderson, however, pointed out that professional apathy is not limited to individuals, but can affect whole groups of specialists. "In nursing, we spend a fair amount of time talking about ethics . . . but we haven't concentrated on knowledge-building," Anderson said. "Ethics is not in the curriculum. It's really studied in a hit-and-miss fashion."

Talk is cheap then, and simply paying lip service to ethics is not conducive to professional growth. "The paradox," Anderson continued, "is the reluctance to establish ethical committees in hospitals and I don't know why that is."

Dr. Jackson didn't know why either, but he added credence to Anderson's statement by calling attention to a national study conducted a few years ago that sought to count the number of ethics committees at medical facilities throughout the U.S. The results, he said, were disappointing: Most hospitals had a committee for establishing official hospital policies, but very few had a separate ethics committee. Those that did, he added, tended to be clumped in areas where medical ethical dilemmas had already occurred (such as in New Jersey, where the Karen Ann Quinlan case unfolded).

If we are to believe the consensus then, in many cases the need for thoughtful, sensitive, ethical discussions in situations that merit it is not being met by the medical profession. The question is, who is going to initiate the change?

Reviewing the issues

After 45 minutes of thoughtful,

sometimes lively, discussion, the two groups reconvened, shared their views, and a list was drawn up. By no means all-inclusive, it lists the most pressing issues, as decided by the group:

- Organ transplants (access to and distribution of organs). Part of the problem here, remarked Charles Reid, a professor of philosophy at Youngstown State University, lies within our system for securing organs. Hospitals and physicians alike are uncomfortable with asking families of deceased patients to donate their loved one's organs, he said, which is creating an organ shortage in this country. Education is crucial, he said, but "We really need to change our attitudes about (taking organs from) people after they die."
- "Quality of life" (Is it considered? Who defines it?).

"Are health-care services truly scarce, and how do we ensure that those available resources are allocated fairly?" Dr. Jackson asks.

This catch phrase has been batted around quite a bit lately, but most workshop participants felt it is still timely. It is just as important, they said, to consider the quality of a patient's life as it is to attempt to prolong it.

- AIDS (prevention vs. prolongation of a terminal disease). "AIDS is a disease that's going to pollute the system," Anderson said. "It's going to break the bank." Others in the group expressed concern that the free dispensation of AZT — an expensive drug that buys a little time for some AIDS patients — is a poor allocation of

resources.

- Termination of life (withholding vs. withdrawing life support). Here group members' opinions varied widely, and more questions were raised than answers given. At what point do we withhold health care? asked one. When the patient is old, terminal, indigent? And when should treatment be withdrawn? At the patient's request? At the family's? Those are issues, most agreed, that likely will take years to resolve.

When all was said and done, no resolutions were passed, no call for action taken. This was, after all, an interprofessional conference, not a congressional session. But the conference *did* fulfill its mission. It fostered a sense of responsibility and professionalism among the participants, it allowed for the thoughtful exchange of ideas, and it exposed a growing

concern for the problems now facing our health-care system.

It even made some participants, like Dr. Williams, observe that shortcomings in the system are to be expected, given the high level of technology that we have achieved. "I think technology has created these ethical issues," Dr. Williams said, "but the pure benefits of this technology by far overwhelms the issues."

Michelle J. Carlson is Editorial Assistant for OHIO Medicine.



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Government Regulation of the Professions

An Interprofessional Meeting of Minds

By Deborah Athy

It was a meeting of diversity. Sitting around the conference table were representatives from a wide variety of professions that comprise the Commission on Interprofessional Education and Practice at the Ohio State University. The participants included a theologian, physician, teacher, lawyer, nurse, social worker, lobbyist, allied professional, and two hospital administrators.

The group was assembled to discuss "Government Regulation of the Professions," one of six workshops offered at the Columbus-held conference, "Issues for the 21st Century: Working Interprofessionally."

D. Brent Mulgrew, JD, Managing Director and Counsel for the Ohio State Medical Association, presented the goal of the workshop in a nutshell: to determine the proper future role of the state and federal government in controlling the professions.

The workshop participants set out to brainstorm this topic and a host of others in a mid-morning meeting of minds.



A slice of the pie

Many of the professions have been involved in "turf battles" in the '70s and '80s, Mulgrew says, vying for reimbursement dollars and legislative power.

"The government is extremely concerned about these turf battles" that have taken up a huge amount of the legislators' time, he points out.

The question is: What is the appropriate allocation of resources between the vying professions? Each profession probably has a different response. "Until recently, the physician has been fairly successful in getting a slice of the ever-shrinking pie," Mulgrew says. But other professions haven't been

as successful in mustering as much legislative strength.

The professionals that currently wield power are the scientific- and high-tech-based professions, he says. Other professions have been left out in the political cold, so to speak. And sometimes, he adds, the professions with the least political power provide the most needed services.

"You can measure the number of widgets or units manufactured by an industry that's given a tax break, but you can't measure the outcome 'manufactured' by support of human services programs," according to one of the workshop participants.

Mulgrew agrees. "It is unlikely that funds will be given to confront unpopular or class-limited social problems. Far more money is allocated to problems that go across the social scale."

A fairly realistic picture of the legislature may be: You can't please all of the people all of the time. "The Ohio legislature must change its face to greet the next interest group and its needs," he points out.

For example, Mulgrew says, in a patient-physician relationship, a physician focuses 100 percent on the patient at hand, in order to make a diagnosis and to suggest treatment alternatives. When the patient leaves, the physician focuses 100 percent on the next patient.

Government works in a similar way in that politicians focus 100 percent on the needs of the group before them. To this end, they will focus 100 percent on a particular interest group one day, and the next day they give their full attention to another group.

However, Mulgrew says, "The government doesn't always look and see how the issues interrelate.

"It's extremely difficult to do long-range planning when government entities are involved," Mulgrew continues. "The government usually will not respond to an issue until there is a crisis."

The Big Bang Theory

But perhaps a critical stage is at hand, he suggests.

"In the 1990s, the problems that were delayed in the '70s and ignored in the '80s will be confronted, or else they will explode," he predicts.

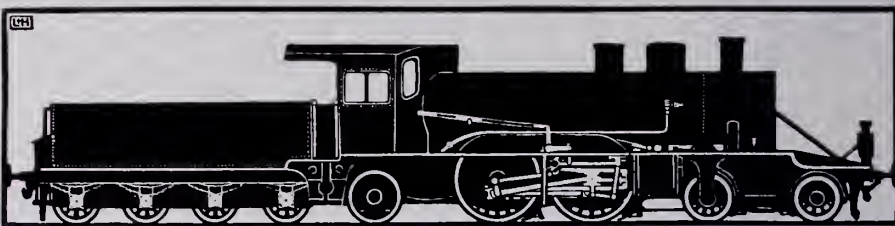
Already health care is moving away from hospitals and into outpatient facilities as a short-term solution to medicine's monetary concerns. Many hospitals are still in financial trouble, he says. They continue to be faced with growing numbers of uninsured individuals demanding expensive health-care services.

We still work under the philosophy that health care should provide the same level of care to all people, Mulgrew says. But if the money is limited, we may be heading toward tiered medical services.

"After trying to limit the growth of government expenses through

regulation, subsidized competition, and, finally, mandated corporate coverage of expenses, the government may simply give up trying to provide equal services to

our dependence on foreign money, to answer the question: Is there going to be an overwhelming financial collapse?, I'd say it's a realistic possibility."



those who are unable to pay," he says.

Unfortunately, the government has already shown that it is unable to manage programs the size of Medicare and Medicaid, he continues. "When the government fails to adequately fund programs that provide equal access to necessary health care and legal services, it will accept the establishment of multiple levels of professional services available to different population subgroups," he says.

Consequently, the fruits of medical progress may not be available for everyone; i.e., only those who have the financial resources will be privy to high-tech medical developments.

It's an unsettling scenario, but Mulgrew doesn't believe the entire framework of the economy will become unglued. He subscribes to the theory of "expanding stagnation," in which our gross national product will slowly continue to increase, but government dollars will shrink. "If the government is not responsive, then a smaller and smaller pie will be available to provide services."

Still, others take a darker view of the country's economic future. As one of the participants put it: "With the trade imbalance, which is hard to get out of, an overwhelming national debt, and

The suggestion that the economy will explode like an ill-fated firework and then fizzle out is indeed a gloomy thought. But the participant did add — and perhaps this can be taken as a note of optimism — that perhaps the economy will end up somewhere between that pessimistic scenario and where we are now.

Mulgrew acknowledges that the country is in the midst of a changing political reality. And while he doesn't foresee the big bang of our economy — in the form of a recession or a depression — he does say the theory contains at least a nugget of truth.

If the professions are motivated by the economy, and the economy collapses, what happens to the professions? he asks. If the professions can be thought of as boxcars on a train, and the economy as the engine, what happens to the train if the engine sputters and dies?

The corporate stethoscope

The physician as businessman? It's a concept that's been under discussion for the past several years.

According to Mulgrew, physicians are changing their view of what they have to do to be successful. Times are a-changing,

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as the song goes, and physicians find they have to change to fit the times.

This transformation is not unique to the medical profession. The perception of what is important is evolving in most professions, according to the conference's opening speaker Thomas H. Walz, a social work professor at the University of Iowa.

"We've lost sight of our primary goals and become self-serving" — a phenomenon he refers to as the "second watershed."

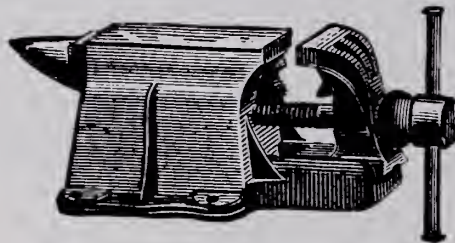
For example, the health field has been transformed by high technology, Walz points out. The fact that it's now referred to as an *industry* underlies this change.

Indeed, what we're witnessing is the *corporatization* of the professions, in which high-technology, big business and the dollar are playing the leading roles.

But Mulgrew says the corporatization of the medical profession is a disadvantage in the political arena. "Medical people may then be perceived as business people interested in their own well-being, rather than their patients," he says. "The clout of being held above the fray will be lost and they (health professionals) will become part of the fray."

Professional groups have far more influence in ethical and financial matters in the legislature when they are able to show how the patient benefits. But if the profession is perceived as a business, it may also be perceived as being only out for itself, he points out.

The bottom line, according to Mulgrew, is that the health profession — increasingly regarded as a health industry — could end up with a smaller piece of the pie and will be unable to effect the kind of changes for the public good that it has worked toward in the last 15 years.



The medical vise

George W. Loesch, MD, a Mansfield gynecologist and one of the workshop participants, says there is universal unrest across the medical profession. A few examples: Physicians are retiring 10 to 15 years earlier; they are practicing more defensive medicine; they are fed up with the cost of malpractice insurance.

In the past, physicians were put on the same pedestal as priests, Dr. Loesch says. "The priest was the conduit between God and man, and the physician was the conduit through which God healed."

But perhaps the high esteem in which physicians were held backfired. Because, he says, "With total power comes total liability."

The changing nature of medicine has also contributed to the vulnerability of physicians. Hands-on practice and a sense of loyalty between physician and patient is being replaced by a more high-tech, low-touch trend in medicine, he says.

And that's not all. Add to this the increasing tendency of the press to grill physicians and depict them as indifferent as long as their black bags are full of profits.

Physicians are getting an unfair rap, Dr. Loesch says. The truth is: "We've done our jobs. We've brought a better level of care to people, but we may be at a breaking point."

He says the government has been unable to meet its financial promises. At the same time, government is trying to tell physicians how to practice medicine.

"I'm getting squeezed by the government on one side and my malpractice insurance costs on the other. I can only be reimbursed at 60 percent for Medicare, but my malpractice premiums are on the rise."

And thus the vise tightens. But, he says, "As the government continues to control my money, I might get less altruistic. Something's got to give."

Big Brother

As epitomized in George Orwell's novel *1984*, Big Brother represents the inescapable eyes of the government.

While our government is not considered to be as all-seeing as that depicted in the book, many professions do find it hard to step out of Big Brother's shadow.

According to a workshop participant in education, "Government is pushing us away from our client base." And, he asks, how can the professions reverse this goal displacement and begin to refocus on their original goals?

He says the teaching profession is essentially controlled by government regulation, such as the school boards and the State Department of Education. This regulation can sometimes pit the teacher against the establishment, he says.

For example, because of the current teacher shortage, the government wants to make it easier for individuals to become teachers, he says. But teachers believe this will lower the standards of their profession. As a result, teachers have formed a professional standards board in attempt to have more of a say in the future of their profession.

After much discussion, which touched upon social work, education, medicine and other professions, one participant sums up: "What I think I'm hearing is

that most groups are feeling a great deal of powerlessness.”

The professions may be linked together in these issues by an economic base. But another participant lays it on the line in this way: As long as the professions are on the government’s payroll, they will probably have to accept Big Brother peering over their shoulders.

The road ahead

There are a number of directions the professions can take from here, though none offer ready answers or guarantees.

But the fact that the professions are looking down the road together is encouraging.

The conference did illuminate some basic realizations within the group. “We’ve recognized there is a second watershed, that there has been some goal displacement. We’ve recognized that the government has created problems. And in some areas, we want less government regulation,” says one of the participants.

Another participant recommended the formation of a coalition group that would represent a variety of different professions. As she says, “We cannot continue to be complacent. We have a responsibility to make a difference.”

But the development of such a coalition — one that would have political clout, one composed of both major and minor players — is a complex endeavor.

But if the professions stand back and do nothing, they may find themselves in an even more complex predicament in the future, she predicts.

But another participant offered a measure of skepticism about the coalition, saying it was a concept that was too idealistic to be realistic. He predicts the chips are going to fall where they may.

But most agreed with the comments of the nursing participant, who points out: “These are overlapping professions, but we are protecting our own turfs, which is dangerous.”

Mulgrew concurs. Considering “the competing pressures from politically powerful groups and the pressure the professions are putting on the legislators, we may be hoisted upon our own petards.”

While it’s too soon to know that definitively, most participants

agree that foresight is a valuable commodity to have on the road to the year 2000.

“We can’t undo what we have done,” Mulgrew acknowledges. But, he says, “History is like a river. With appropriate dams and channeling, we can influence the way it flows, but we cannot stop its movement completely.”

Deborah Athy is Associate Editor of OHIO Medicine.

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SPECIAL POPULATIONS

Who Are Tomorrow's Patients?

By Karen S. Edwards

The list of special groups, each with separate wants and needs, seems endless. You probably already know. In fact, you're probably seeing a good many special population groups in your practice *now*, and you're making adjustments to care for them all — the AIDS patients, the elderly, the Medicaid-eligible, the physically disabled, the homeless, the unwed mothers, the adolescents, the athletes, the terminally ill, the sexually abused.

Daily, it seems, the groups — as well as those within each group — troop into your office with new needs and new demands — for as their numbers increase, so too does their strength. But how can you — or any professional — hope to help them all?

That was the question posed to a group of professionals this past spring in Columbus at a workshop on special populations, sponsored by Ohio State University's Commission on Interprofessional

Education and Practice. The workshop was moderated by Sarah Neikerk who, as Executive Director of CALLVAC services, a telephone referral service in Columbus, is not only well aware of, but sensitive to the needs of these special interest groups.

The professionals' first task was to understand *why* specific population groups develop. Some, of course, deemed their organization as inevitable.

"Everything is specialized these days," says Neikerk. "Even the support-group phenomena which has grown out of these special populations has become so narrowly defined."

Suicide support groups, for example, are now separated in numerous ways. There are groups for those who are just thinking about suicide; for those who have thought about it — and tried it; for those who used pills; as well as for those who have used some other means. Then there are

groups for those under 18 years of age who have attempted suicide; for those over 70 . . . the list can, unfortunately, go on and on.

The *reason* these populations become so specialized, Neikerk explains, is to bring focus to *their* problem — to their unique needs.

For with attention, after all, comes money — funds from the government or private sectors — and with money come programs and professionals who can help.

Admittedly, says Neikerk, some programs are developed because those in control of the purse strings want to see a specific group eradicated — because the group may offend certain sensibilities.

"The homeless are a perfect example," she says. "The homeless program came into power because certain people didn't want to see them loitering around (the parks) anymore." So, she continues, those in control of funding dollars set about to see whether or not

continued on next page

something could be done about the problem.

In fact, all of the professionals are inclined to agree that politics, as well as the battle for funds, play a large part in creating special population groups.

"Every four years, we have people who recognize and address the needs of these special groups — then they forget about them the minute they're elected into a position where they could be of some help," says one participant.

Consequently, it's not difficult to understand why these forgotten groups then organize and start to lobby legislatures for laws and regulations to help them get their needs met.

For some, it has been an effective ploy — but there are negatives to belonging to a special population group as well — ones of which the professionals in the workshop were well aware.

"There is a danger in assuming that everyone in a specific group is alike," notes one. Indeed, it's conceivable, they say, that these special population members will begin to mold into a kind of definitive personality.

"Then we begin to anticipate their treatments, because we say we know this group so well. A person who is uncharacteristic of the group won't stand a chance."

There is also the danger of a person falling into two specialized groups — the homeless families, for example. How are these people "pegged?" they ask. As members of the homeless group? As broken families?

"All of it will depend on where the bucks are," notes one participant.

And that seems to be the bottom line.

"If someone is identified as being a member of one special population group, it prevents him from drawing benefits from any other group he may be part of,"

comments another participant.

The homeless client, for example, is better served if he or she is identified as an alcoholic — and so the professions juggle the terminology, the groups, the forms, and, indirectly, the patients or clients, to those areas where they might be best served. But there is presently no advocate for these people, notes Neikerk. There is no one to follow them through a long-term relationship, pulling across all of the disciplines to ensure they get the help they need.

And why not?

The consensus seems to be that the polarization of the professions is to blame — that reluctance to step across boundaries or turfs.

A perceived hierarchy of the professions, for example, have those who see themselves in the "lower stratosphere" quick to protect that which they have . . . and that which they see slipping away.

Says one social worker: "Articles which deal with those areas we used to be involved with — like helping the victims of violence or suicide — are now appearing in medical journals. It seems that other professions are moving into areas where we should be," she says.

In some respects, that can be healthy, they agree — and, from an interprofessional standpoint, *continued on page 558*

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Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.



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Mytrex[®] CREAM AND OINTMENT, USP

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Brief Summary of Prescribing Information

For Dermatologic Use Only
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INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.

CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.

PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see **DOSAGE AND ADMINISTRATION**). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see **PRECAUTIONS, Pediatric Use**). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetonide, treatment should be discontinued and appropriate therapy instituted.

Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see **DOSAGE AND ADMINISTRATION**).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test; ACTH stimulation test.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetonide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetonide Cream cleared or significantly ameliorated the disease state in most patients. Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio. HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetonide in clinical studies.

Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.

The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and milia.

DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX[®] (Nystatin-Triamcinolone Acetonide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX[®] is usually applied to the affected area twice daily in the morning and evening. MYTREX[®] should be discontinued if symptoms persist after 25 days of therapy. (See **PRECAUTIONS, Laboratory Tests**). MYTREX[®] should not be used with occlusive dressings.

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Special Populations . . . continued

one would think desirable. Yet still, it's presented to the group petulantly, defensively.

Once again, it seems to boil down to economic matters. If there are dollars to be had in caring for specific population groups, the professions scramble for territory. If no funds exist, then that particular group's needs remain unserved.

That this is occurring on a secular level is not surprising — that it also appears to be happening on a spiritual level, however, is astounding.

One theologian who attended the workshop noted that he is beginning to see more and more members of his congregation become "dogma-oriented," anxious, that is, to retain the unique characteristic of their church and their religion, but moving further and further away from applying that dogma on a practical level. In fact, he says, they are becoming less and less willing to move out and serve the community, preferring, instead, to remain in their own church population — in fact becoming,

Next Month in OHIO Medicine: The 1988 OSMA Annual Meeting

for all intents and purposes, their own special population group.

"It makes you ask, who is the heretic?" he comments wryly.

"The church has to lose its special identity as well (as the professions)," he says. "It seems now that we (the church) need a label before we will honor an activity. That's why theologians need to get out — to get away from talking to each other, and talk instead to those who are in other professions."

Indeed, exposure to other positions and views may be the healthiest tack for those who are working in different disciplines — seemingly at odds with each other — to take. That way, everyone can be heard — all positions made clear.

"We need more active collaboration, more communication between the professions," agrees one social worker. "Presently, there is so much fragmentation of services that clients can get overwhelmed by the number of places they must go to receive services. This is a problem that needs to be addressed interprofessionally."

Besides coordinating care, she points out, such communication could also help avoid duplication of services.

"There is a need for earlier working together," agrees one educator. "It's happening now — but not quickly. We need to network those professions which are working with special population groups so that treatment or help can be both cost effective and complete."

Finally, all of the professionals championed the need to make ethics a higher priority in the disciplines.

"It's immoral," they say, "to have a need, yet provide services only to those who can afford it."

Still, that reality exists, and despite the rhetoric and best

intentions, it may take a while before the reality can be dispelled.

And until it can, chances are that tomorrow's special population

groups — be they patients, clients or even worshippers — are apt to be the same groups who are vocalizing their needs today. **OSMA**



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By Karen S. Edwards

Technology and Aging: A Glimpse at the Future

Introduction

This article concludes the series on "Technology and Aging" which began in our June issue. You've already met the elderly and glimpsed some of the technological innovations that are extending and improving their quality of life. In this article, we'll examine how designers, architects and robotic technologists are planning to cope with our aging population in the future.

The designer's view

Picture a range — an ordinary stove in your own home.

Now, picture yourself 75 years old and about ready to cook your dinner.

First, you must reach the control panel — all those knobs and dials which are set awkwardly on the back of the stove. With your arthritic fingers, those dials are hard enough to operate — but it becomes worse once your dinner is finally heated. Then, of course, you have to reach over the steaming pot or pan to turn the knob to the "off" position . . .

wherever *that* might be. After all, most type on those dials is pretty small and they mix so many typefaces back there, you're never quite sure what each change in typeface is supposed to mean.

Of course, you *could* be less fortunate. You could have one of those coding diagrams with the tiny colored dots which shows you which knob operates which burner. Now that you're seeing colors with less intensity (and the color blue hardly at all), such a device could easily spell disaster. Besides, the glare from all that chrome trim and the stove's slick, shiny surface is making those miniature letters hard enough to read . . .

"No wonder that 25 percent of all the microwaves being sold today are being sold to those over the age of 65," says Joseph A. Koncelik, professor and chairperson, Department of Industrial Design at the Ohio State University.

Think about it, he says. Microwaves sit on countertops so they are right at eye-level. There is no bending over to open heavy

oven doors — or to read control panels, since microwaves feature *theirs* conveniently up front, or on the side. It's a design that makes sense for the elderly, he says — and maybe it's about time more designers began to think along the lines of designing for an elderly population.

"Originally, control panels were put in back of stoves to keep them out of reach of children," Koncelik says. Now, however, children are not found as frequently in today's homes as are elderly parents or residents. "It's a simple matter of changing design to meet the needs of another population group — one which, in our society, is growing larger," he continues.

And better design, *may* do as much to extend the elderly's independence as the latest technological innovation.

"Technology is a freight train rolling down the track. If you're in its way, it will knock you down," says Koncelik.

In fact, technology can — and often does — get out of hand, he
continued on page 563

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asserts.

"I call the 52-channel remote control for our television set 'overstatement of technology.' Our five-year-old grandchild is the only one who can work it," he says.

Then, there is the microprocessor in new-model cars that assimilates all the information about that automobile's well-being — and gives it to you all at once.

"Studies have shown that the time a driver spends viewing the displays on the dashboard are negligible. Drivers read only the speed and the fuel gauge, so a shaft encoder was developed which allowed information to be presented only when critical. Now we're back to getting it all at once," he comments.

And that, according to Koncelik, leads to a modern-day phenomenon known as "technology for the hell of it."

"If you can do it, you do it. No research is undertaken — and that's an absurd way to proceed with a design."

While Koncelik will admit that most present-day designers lack the time and skill to do much research, they could benefit from studies done on the elderly — especially the effect of sensory loss on the aging consumer's needs.

"The best data we have comes from a 1962 study," says Koncelik. "We need more up-to-date information. A sensory loss study should be done every 10 years," he says.

Designers could then incorporate that data (and the needs indicated by that data) into their designs.

It need not be a *major* change, Koncelik continues.

"Even small changes in the environment can impact dramatically on the elderly. They may even help the elderly decide whether to venture outside or not."

What type of changes does Koncelik envision designers

working on in the future?

To begin with, chairs for the elderly definitely need improvement, says Koncelik.

"To get up, the elderly depend on every muscle in their body to get the center of gravity out over their heels. That's why the arms of the chair are so important."

He would like to see chairs for the elderly have arms that are longer than those on today's typical chair — moved outward. He would also like to see a chair that can change the height of its seat — allowing the elderly a better chance to push out over that center of gravity. Small changes, to be sure, but important ones for an elderly population.

Other changes Koncelik would like to see designers tackle:

• Bathrooms

- grab-rails placed in strategic locations. "One grab-rail by the tub or toilet doesn't make it," he says.
- raised toilet seats with bars on each side.
- for non-ambulatory elderly, mirrors moved down to a location just above the sink's backsplash. "So they can see themselves," he says.

• Institutional space

- more room at bedside and safer flooring. "Eighty percent of all falls take place at the bedside, and 20 percent of all elderly who fall die from their injuries."
- social areas built around an active (as opposed to a passive)



activity place. "We've learned seniors won't congregate around a window with a pastoral scene — they go to the window facing a parking lot," he says. Even the pastoral scene, however, beats the room that's "designed around the swath of a mop" — chairs lined up on either side, with nothing in between.

— designing a maximum difference in corridors, so seniors can distinguish one from another.

How soon does Koncelik see these design ideas taking shape?

Unfortunately, not anytime soon, he says. Manufacturers are not racing to the starting line to produce "elderly goods."

"There is an under-capitalization of manufactured goods for the elderly," Koncelik says. Even if a manufacturer *can* launch a product successfully, "Few can stay with it long enough to have it accepted."

In order to achieve consumer acceptance, Koncelik continues, the piece must be aesthetically appealing.

"If it looks orthopedic, they won't want it," he insists.

So, designers are attempting to make those chairs for the elderly look less out-of-place; to make grab-bars look less like tube-bending hardware.

Once that's accomplished,

however, the trick is to find a manufacturer that will produce the good — and that's not easy, either.

"Manufacturers don't understand the dynamics of aging," says Koncelik.

They see only a plethora of needs which must be met . . . too many needs to be addressed specifically . . . so they back off.

"GM can't make a general car that will be suitable for *all* elderly drivers," Koncelik gives in example, "so they don't make one."

Still, he says, 65 percent of all new cars bought today are bought
continued on page 566

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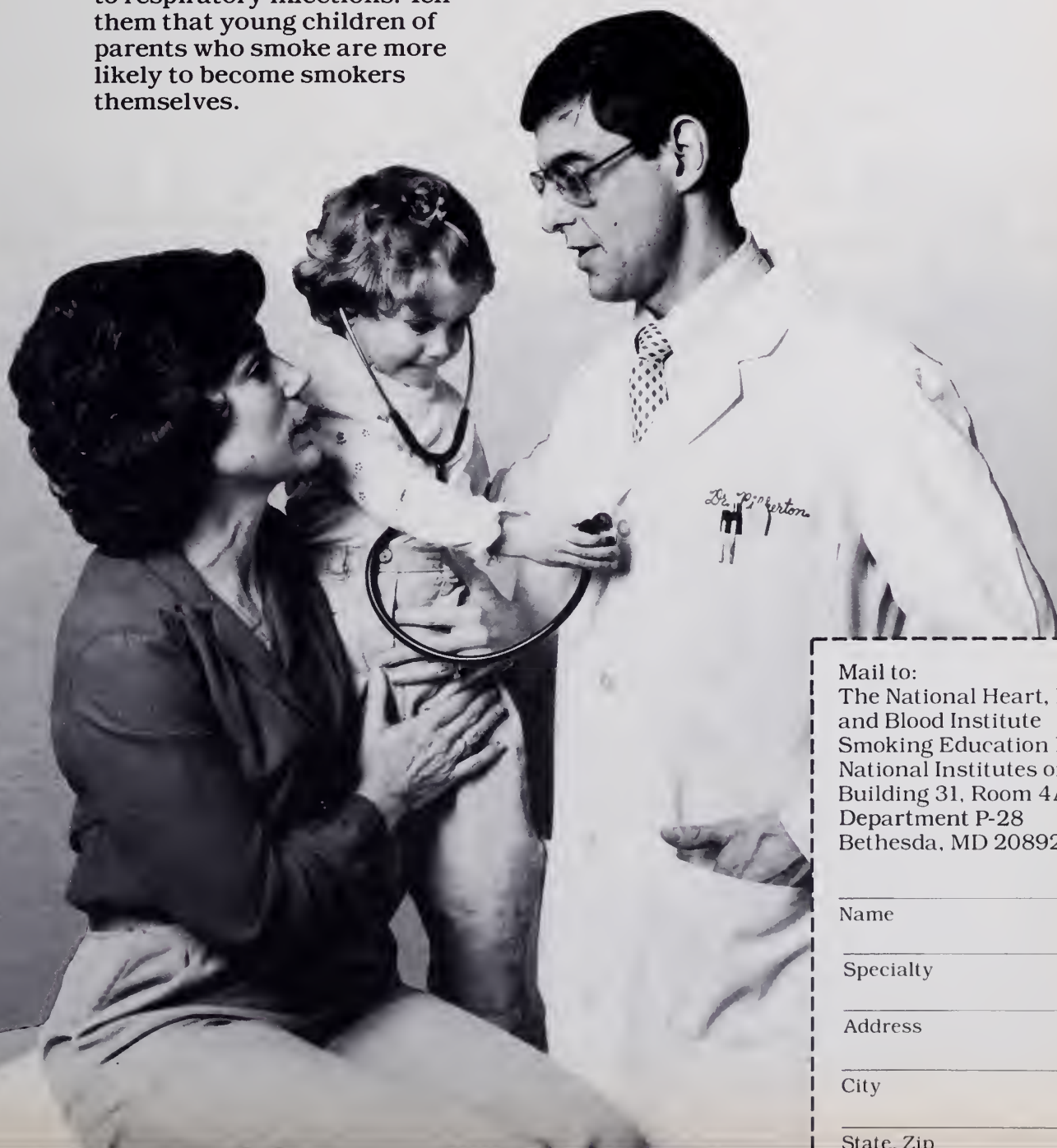
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2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, *OHIO Medicine*, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of *REFERENCES* should be *DOUBLE SPACED* with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) should bear the figure number and author's name on back. When pertinent, the top of the photograph should be indicated. Do not clip or write on the back of the photos with a hard pencil, etc.

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5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

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(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

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12. **EDITORIAL ASSISTANCE.** Michelle Carlson, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Technology and Aging . . . continued

by those over the age of 65.

"Yet the elderly are still ignored in the design process."

Eventually, manufacturers may change. After all, as the market for elderly goods increases (as it's bound to with the coming of age of the Baby Boomers) — manufacturers will most likely scramble to meet the demand.

Until then, says Koncelik, they'll continue to focus on groups they can understand.

"It's easy to manufacture goods for the 25-year-old group and younger. You only need three sizes of blue jeans. For my generation and older, however, you need 225 sizes."

And to today's manufacturers — that's a stalemate.

The architect's view

Architects are equally as concerned about this delay in the production of elderly goods. They understand it, of course.

"New products involve a substantial investment," says Victor Regnier, an architect and associate professor at the Ethyl Percy Andrus Gerontological Center, University of Southern California, Los Angeles.

"There are expensive prototypes to be made and all those marketing questions that need to be answered. Yet this is what keeps ideas from moving into production," he continues.

So instead of looking forward to new technology, perhaps the most promising field right now, he says, is low-technology . . . that is, minor adjustments that can be made to an older person's environment to help him or her overcome a number of troublesome problems affecting daily living.

Regnier offers several examples — door levers instead of door knobs (which often fail to turn in an elderly grasp); large, lever-like devices to turn on and off stove burners; large knobs on light

switches.

"What we have to realize," Regnier continues, "is that older people live in older homes" — and very few of these older homes are designed for elderly living.

Three spaces in the home that consistently present problems, Regnier continues, are the kitchen, the bath and the stairs.

Like Koncelik, he is also concerned with the number of falls the elderly have — not just in bedrooms, but down stairs as well.

"We need to make the stair nose easier for the elderly to see," he comments.

Wide fluorescent tape, placed on the edge of each stair, will help the elderly judge distances better and enable him or her to tell exactly where the stair drops off —

"instead of reading it with their feet." Installing handrails would also help — and all of this could be accomplished for much less than the \$2,500-\$4,000 it costs to put in one of those devices that move a person up stairs mechanically, he adds.

What about the kitchen? What can be done to make this room more usable by the elderly?

"The inability to reach and bend are two of the biggest complaints we hear from the elderly," Regnier says.

Therefore, architects are now looking into designing kitchens where little of either activity needs to be done.

"The elderly usually move to more lateral storage," he says, so shallow shelves, cabinets and cupboards — rarely more than a foot deep — are placed about the room. Roll-out shelves and easy-to-pull-out drawers are also common.

A kitchen prototype, now being developed by Advanced Living Systems, divides the elderly kitchen of the future into two separate alcove areas. Both are U-shaped, with corners eroded for easier access. One alcove contains the

sink, stove and refrigerator; the other the pantry and storage space. There is a pull-out stool for the counters, and a small desk in the pantry area for inventory or menu-planning.

"The prototype design can be installed at only \$200 over the cost of a conventionally-designed kitchen," says Regnier, adding that the prototype is so close to being available now that he predicts it will be on the market before the end of the year.

The bathroom is yet another area in the home that qualifies for some low-tech adapting, Regnier continues.

"Faucets should be changed to a

rocker-control mechanism, and the taps should be color-coded to differentiate hot from cold," he suggests.

Again, like Koncelik, he believes more handrails need to be placed around both the tub and toilet areas — "but they should be better looking than the stainless steel bars we typically see. They make a tub look institutional," he says.

Looking ahead to the high-tech end of change, however, Regnier says designers are coming out with tub designs specifically geared for elderly users.

One example is a side-opening tub. It allows you to sit on the tub to test the water, then, when it's

right, you open the door, climb in and allow the tub to fill.

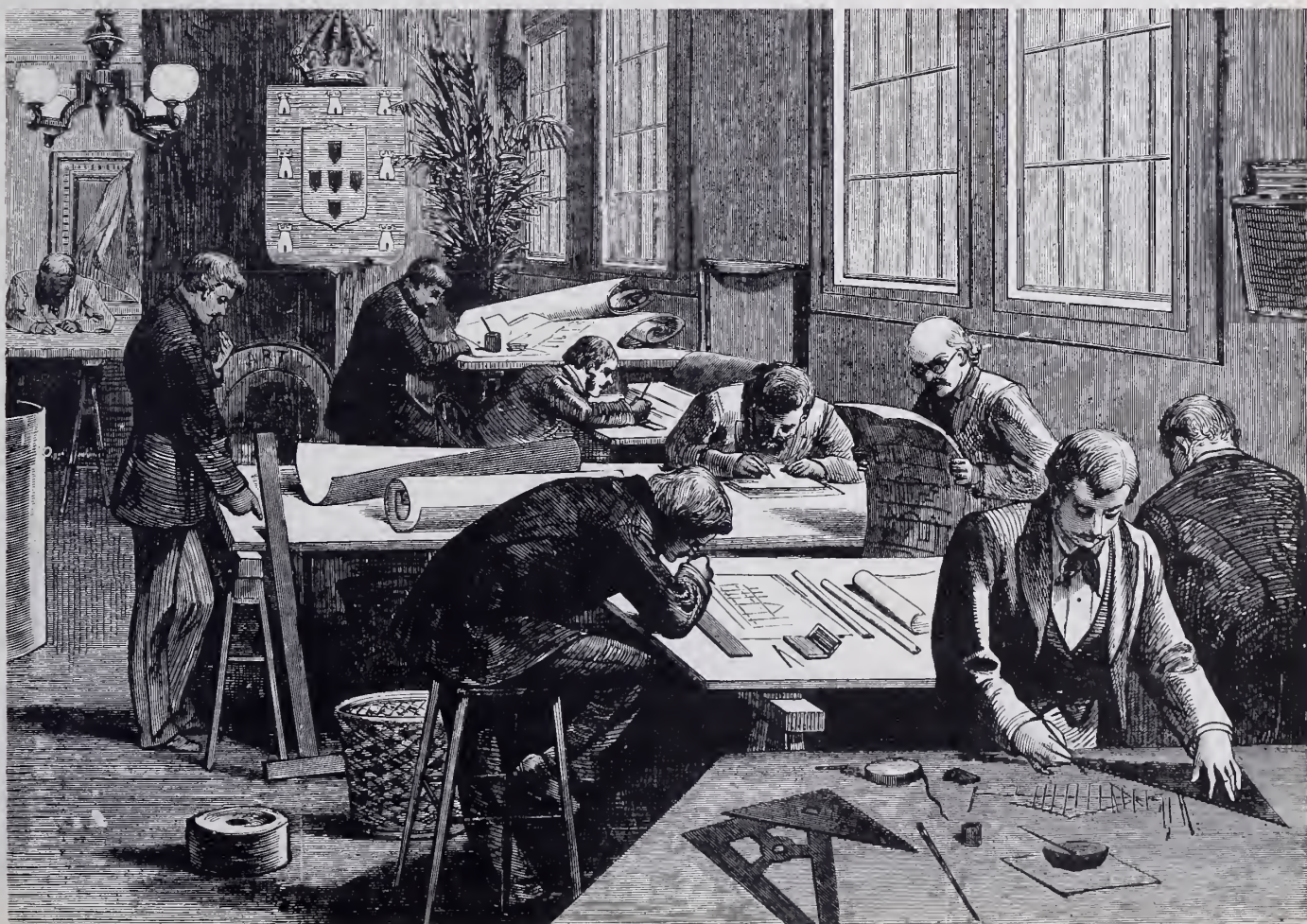
"Besides the easier access, the tub is easier to clean," he comments.

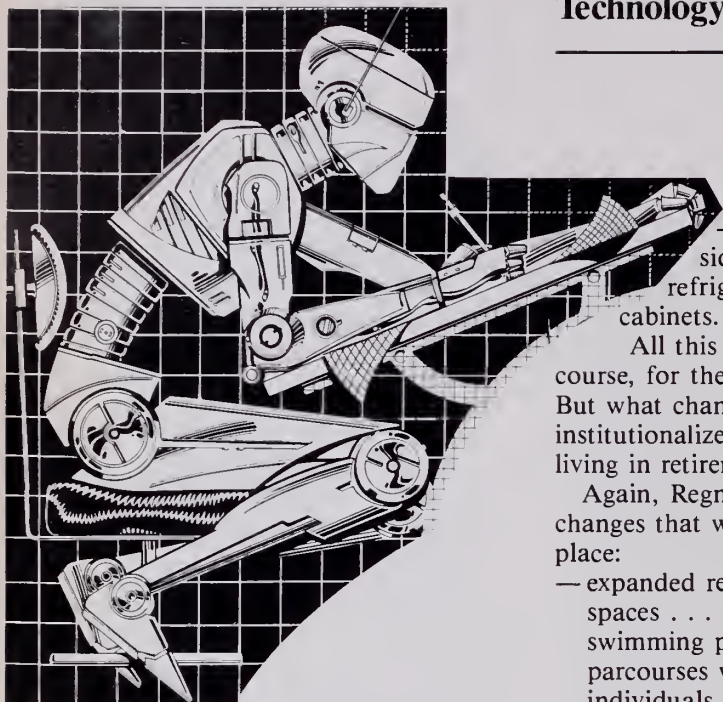
Of course, such high-technology doesn't come cheap.

"A tub like that would cost \$1,799 to purchase," he says — but manufacturers are exploring a rather unique way to make such technology affordable.

"Currently, contractors can purchase a shell for the tub for about \$400," he says. Later a module adapting the unit to its side-opening ability can be purchased for the remaining amount.

"This plan also allows





— eye-level ovens,
side-by-side
refrigerators, lower
cabinets.

All this is well and good, of course, for the resident at home. But what changes await the institutionalized elderly — or those living in retirement communities?

Again, Regnier proposes a list of changes that would like to see take place:

- expanded recreation and exercise spaces . . . “especially swimming pools and outdoor parcourses which allow older individuals to exercise privately.” He adds that hi-tech exercise equipment is also likely to find its way into elderly housing projects in the future.
- drugstore technology (i.e., machines to check your blood pressure) will become commonplace fixtures at these facilities.
- individualized corridors and doors — set off by such niceties as sisal mats, nameplates and plants to make each room feel more like a house occupying a neighborhood.
- corridors will also be opened to more natural light, with wide expanses of windows opposite rooms. (“This helps orient the elderly to where they are in the building,” says Regnier. “They can examine their location by checking for clues outside the window.”)
- bright graphic maps and directional devices on walls to further help in navigation.
- sole-sensor shoes that allow patients with Alzheimer’s or dementia to wander the facility or grounds — but still be managed.
- more social rooms where people can gather. Some retirement homes already feature ice cream shops and delis.
- video monitors that report daily and weekly activities. This

allows the elderly resident to get involved in an activity on the spur of the moment.

- videophones for visits with grandchildren and great-grandchildren.

“And the robotic devices that are emerging these days show enormous promise,” Regnier concludes.

The robotic engineer’s view

Now, at last, we’re into the epitome of high-tech. Robots — artificial intelligence products — that sense, think, move, act.

“We know that robots can be turned into useful tools to serve humans,” says K.G. Englehart, senior research scientist and director of health and human services at the Robotics Laboratory, Carnegie-Mellon University in Pittsburgh. “What we need to do is to start thinking about robots intergenerationally.”

Robots can be divided into three types, says Englehart. There are industrial robots, personal robots and educational robots. Industrial robots are the ones that have been most thoroughly developed to date — and many have actually been placed in factories to assume some of those repetitious tasks human workers find odious at best.

Personal robots can be developed for the same reasons, says Englehart.

“Robots can increase the independence of the patient and caregiver — they can increase the quality of care by assuming those tasks humans find too demeaning, demanding, dangerous or boring.”

A robot, for example, can be programmed to do housekeeping chores; to assist in transferring, lifting and transporting elderly patients; to assist them in ambulation; to ‘de-puddle’; and to fetch and carry.

“Studies have shown us that ‘robotic helpmates’ can assist in or assume 12 nursing tasks, 17 patient

acceptance of the product at an early age,” Regnier adds.

The bathroom of the future might also contain a dressing table, again with rounded corners, and a swivel stool.

“And the toilet will be higher, and at a 45-degree angle to enable a squatting position,” he adds.

Any housing that is being developed now, however, needs to be planned in anticipation of these features, Regnier emphasizes.

“It is less costly to build homes with these features than to remodel existing homes.”

And the home of the future — what will it be like?

Regnier lists the possibilities:

- 2- to 3-bedroom units
- swing-room designs (i.e., a second bedroom that is linked to the living room. This will enable the living space to be extended into that room if necessary — or the bedroom could be blocked off and used for that purpose.)
- thermostats designed with large numbers and auditory signals, like clicks, to count off degrees.
- body temperature-sensing devices in each room, allowing the thermostat to switch on or off, depending on whether or not someone is in the room.
- revolving racks in closets

tasks, seven therapist's tasks and nine tasks performed by an administrator," says Englehart.

In addition, a robot is able to complete 13 jobs in a kitchen; 10 in an operating room; and at least 10 in a long-term care facility.

"Our basic research into robotics is needs-driven," insists Englehart. "If we are designing a robot to assist a specific individual, we go to that person's workspace and assess the problems there."

Despite the fact that robotic technology is moving forward, however, Englehart says it's not there yet.

Larry Leifer, associate professor of mechanical engineering at Stanford University and director of the Stanford Center for Design Research, agrees.

"It will be another 50 years before we have a model we're proud of," he says.

Part of the problem, he explains, is that robots now operate in structured environments.

"We need to be able to unbolt them from tables and get them to operate in a normal, unstructured environment," he says.

He also agrees with Englehart that the field is moving away from developing industrial robots and is concentrating more now on personal robots — ones that can assist their users with tasks like food preparation and personal hygiene, i.e., tooth-brushing and shaving.

"By providing the elderly or the disabled with a general purpose tool, we can give them access to other, everyday tools in their environment," he comments.

But are older people ready to turn over tasks to these mechanical creatures?

"We need to introduce robots to the elderly population in a gentle way," says Englehart.

But don't forget, she adds, who tomorrow's elderly are going to be.

"These are people who are college-educated and with a \$40,000-a-year income," she reminds us. "Older people in the future will not be technophobic. They're dealing with machines now — automatic teller machines, for example."

Harvey Sterns, a professor of psychology at the University of Akron carries that thought even further.

"There has always been the introduction of new technology to different age groups," he says, pointing out that his parents adapted readily to such gadgets as electric razors and automatic transmissions.

"In fact," he continues, "many of today's older adults have been on the cutting edge of today's computer technology."

Englehart adds: "These are the folks who split the atom and who got us into outer space. We can't just leave them behind."

"The elderly are quite ready to adapt to technology if they don't see it as expressing dependency," comments Dennis La Buda of the Technology Center for the Aged in Miami, Florida.

Mildred Seltzer, of the Scripps Institute for Gerontology in Oxford, Ohio follows up: "Dependency in our society is equated with weakness. The elderly love gadgets — they want them in their homes — but at the same time, they don't want to give up their independence."

Englehart is quick to assure that robots of the future *will* be user-friendly.

"That's why we're working on voice-activators rather than buzzers or bells," she says — despite the fact that voice-activators *can* be troublesome.

"We've tested it. There are at least 21 ways to tell a robot to go right," she says with a laugh.

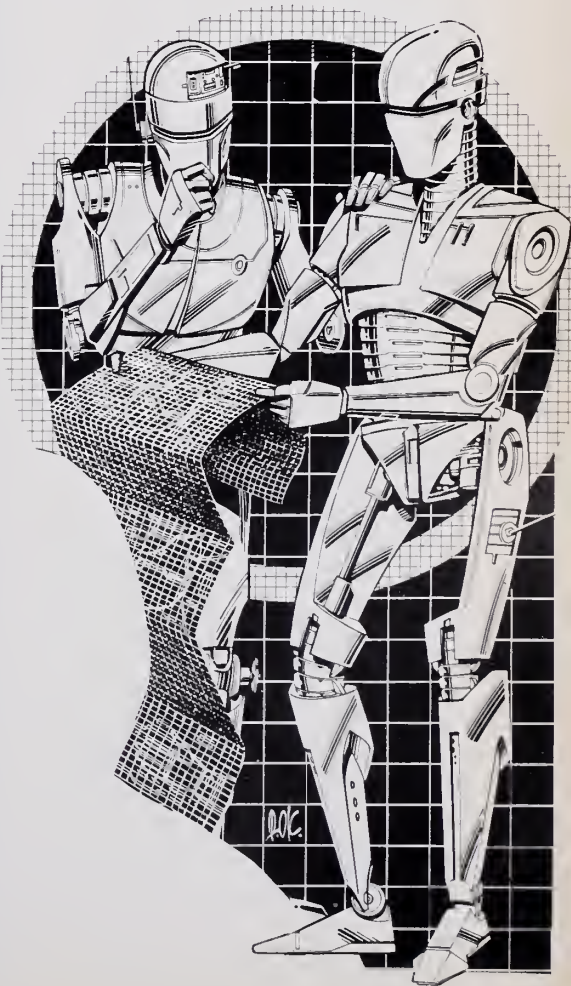
Vocabulary can be yet another problem.

"My grandmother might tell a robot to turn the hi-fi down — and the robot won't know what she means because we've programmed it to recognize the word 'stereo.' "

Still, the elderly need robots with easy-to-operate controls — and the human voice, the simple act of speaking a command — is the easiest way for the elderly to achieve that control, she says.

What, then, are some other robot requirements?

"Redundancy works so well on us, the biological model — what with our two lungs, two eyes, two ears, two kidneys, and so on — that we're beginning to design



robots with similar back-up systems," she says.

And believe it or not, aesthetics play a bigger role here than those stainless steel grab bars in the bathroom.

"The elderly won't use a system they are embarrassed to have in their environment," she says.

Once the elderly have accepted robotics — and assuming the development of this technology continues on course — what will tomorrow's robots be capable of doing?

"Let's begin with the kitchen," says Englehart.

They can do food preparation and clean-up chores, they can weigh food input so they know exactly how much food has been consumed — and remind you to order more.

Moving on from there, robots can:

- nag you to take your medicine.
- assist in gait-training and range-motion exercises.
- shop for you. "A design for a 'smart-cart' is on the drawing boards," says Englehart. "It's equipped with a bar code reader so you're not stooping over to read those price labels. It will keep track of your total, and you can program it with the nutritional needs of an individual, so it will report and advise you if you pick up something you shouldn't have."
- wash clothes. "It's still having trouble sorting them, however."
- And a robot will soon
- transport people — a three-wheeled cart is now available that glides, turns and pirouettes with all the grace of a dancer.

"Robots will be whatever human beings want them to be,"

Englehart sums up, adding:

"The good thing about these labor-saving devices is that they're for everyone — old and young alike."

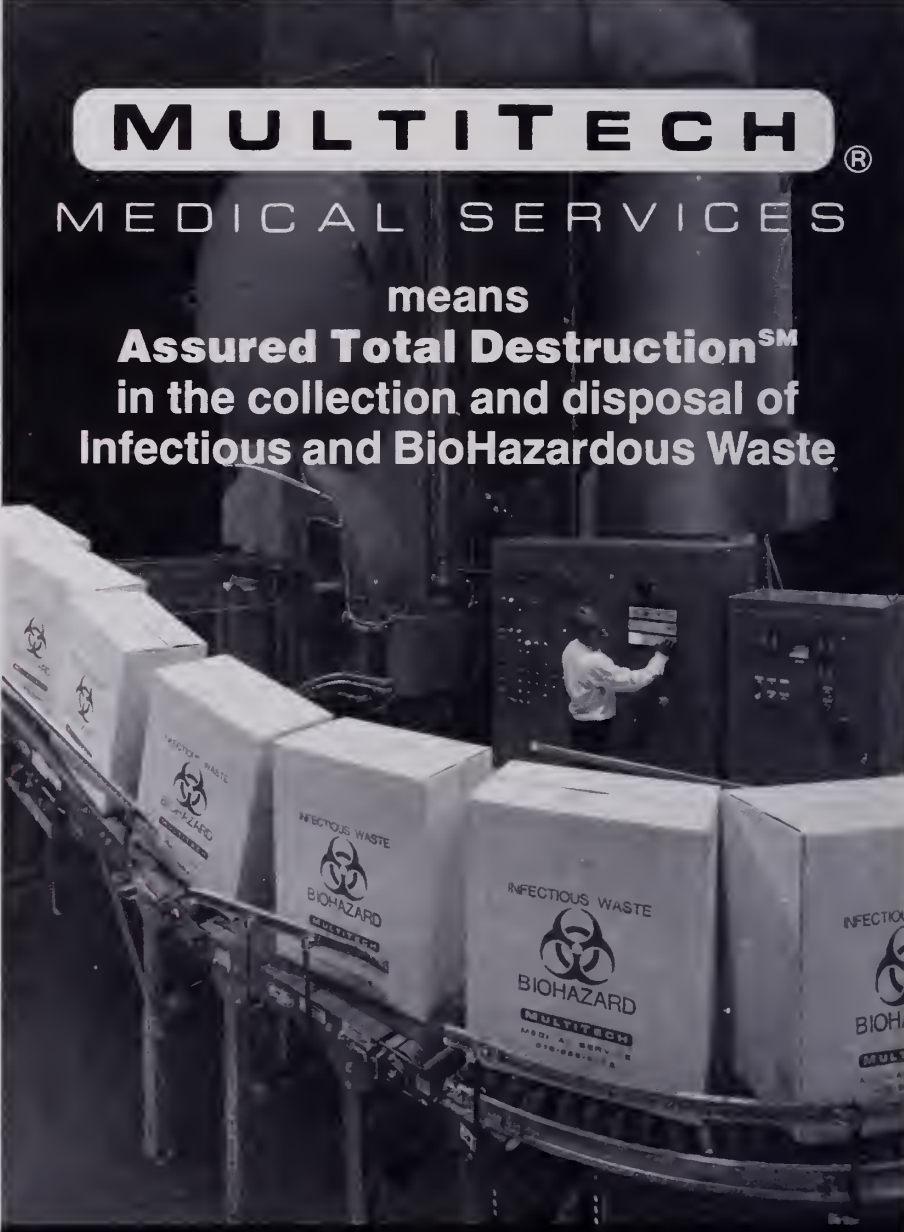
For example, she continues, won't the development of a smart

vehicle keep our teen-agers as safe as our elderly? Won't the stove burner that turns red the instant it's turned on protect our children as well as their grandparents?

"Robotics will not be a panacea to all the elderly's ills," she is

quick to attest. "But they will be another tool in our arsenal of hope." OSMA

Karen S. Edwards is Executive Editor of OHIO Medicine.



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Variations in Medicaid Surgical Rates Across Counties

An Ohio Department of Human Services Study — 1982-1985

Editor's Note: *The following report details the results of a study conducted by the Ohio Department of Human Services on the rate of selected elective surgeries among Ohio Medicaid patients. The study, which shows wide regional variations in surgical rates, was released at a press conference called by ODHS on April 20, 1988. Richard B. Reiling, MD, FACS, immediate Past President of the Ohio Chapter, American College of Surgeons, appeared at the conference on behalf of Ohio Chapter, ACS and the OSMA. His remarks are included in this article.*

ODHS has pledged to work with OSMA and the surgeons in order to help resolve the problem. All involved groups believe education is the key to lowering utilization rates. Should this effort fail, ODHS has indicated it will consider instituting a second surgical opinion program for Medicaid patients.

The delivery of unnecessary health services to welfare clients is a major concern of the Ohio Department of Human Services. Many health-care procedures involve significant risks for patients, and unnecessary health services add to the cost of the Medicaid program which is already one of the largest line items in the state budget.

How do we identify unnecessary health services? In the last few years there has been a growing interest in the large variations in health services across geographical areas. In a series of studies, Capor and Wennberg have observed striking differences in the delivery of these services from community to community, and have concluded that these variations are not due to illness factors nor to other differences in health-care needs. According to Capor and Wennberg, there is disagreement within the medical community as to the efficacy of many medical and

surgical procedures, and as a result physicians in some areas do these procedures more frequently while those in other areas practice more conservatively.¹

Unfortunately, none of these findings provide a clear guide to policy. We do not know whether the areas with high rates of medical service are too high, or the areas with low rates too low. There are no generally accepted normative standards in this field. But the Capor-Wennberg findings are still significant because they lead to the obvious question: If the variations in medical services across areas cannot be explained on the basis of illness or demographic factors, aren't the more conservative practice styles preferable?

The next question is, what should government do about this? Many states have adopted utilization review initiatives like mandatory second opinion programs for elective surgery

which require welfare clients to consult with a second physician about the desirability of a surgery before the state will pay for it.² These approaches have often been controversial within the provider community, and there is still no consensus as to their effectiveness.

One alternative relies on public education. Caper and Wennberg have shown that when physicians in a particular area are apprised of the fact that they exceed the norm in their practice patterns, they frequently respond by changing their styles: reducing surgery and substituting less intrusive procedures or otherwise cutting down on the services they prescribe.

This is the approach we are currently pursuing in the Ohio Department of Human Services. Over the last year, we have identified large variations in rates of elective surgery among welfare recipients in the 88 counties, and we have been working with the state medical society and other professional associations to see whether we can explain these variations. We plan to share our findings with surgeons across the state in the hopes of achieving the kinds of reductions reported by Wennberg and Caper. If we find that the variations cannot be explained by any measure of need, and if we do not succeed in reducing the rates in the high-surgery areas through public education, we can always adopt a regulatory solution. For now, however, we want to see whether the educational approach will work.

In the analysis that follows, we look at utilization data for 10 elective surgical procedures in the period 1982-85.³ These procedures were chosen because their rates are known to be highly variable across geographic areas in the U.S. The approach was to aggregate all the surgeries performed on the welfare recipients residing in a particular county — whether those surgeries

were performed in that county or elsewhere — and then calculate a rate of surgery per 10,000 Medicaid recipients. These rates were then compared across the 88 counties.

This report is divided into two sections. In the first part, the county is the unit of analysis. Here we look at variations in surgical rates across all of Ohio's counties, as well as between the rural and urban areas. In the second section of the report we focus on the state's more populated areas. We identify the differences which exist between metropolitan areas even after relevant demographics, such as age and sex, are taken into account.

Surgical Rates by County

The average rate for all counties from 1982 to 1985 comes to 240 surgeries per 10,000 Medicaid eligibles. Yet it is clear that there are significant variations across the state. In some counties, the rates were as low as 150 surgeries per 10,000 Medicaid eligibles, while in other counties the surgical rates were over 300. Thus, the counties with high rates had more than twice as many surgeries per capita as those with low rates.

There were also markedly different rates of surgery even within neighboring counties of the state. For example, in the northwest section of Ohio, Fulton and Henry Counties had below average rates, while Sandusky and Williams had above average rates of surgery.

The surgical rates for Ohio's rural and urban (metropolitan) counties are compared in Table 1. The averages for the two groups are quite similar — 235 for the rural and 241 for the urban counties. However, the surgical rates of the rural counties did vary much more noticeably than those of the urban counties.

Despite these variations, it is also important to note that the counties' surgical rates did remain

very stable over time. Counties with above average rates in 1982 also had above average rates in 1983, 1984 and 1985.

Surgical Rates of Metropolitan Areas

The number of surgeries performed on Medicaid eligibles within the main metropolitan areas of the state was also analyzed. This allowed us to compare surgical utilization patterns in the areas of the state where most welfare recipients reside and where most of the elective surgeries are performed.

The average surgical rates for Ohio's metropolitan statistical areas (MSAs) are displayed in Figure 1. There are indeed large variations in this time period from one MSA to another. The highest surgical rate (350) was recorded in Marietta and the lowest (155) in the Cincinnati-Hamilton area. Again, the rates for individual MSAs do *not* change significantly throughout the four-year time period.

Researchers like Caper and Wennberg believe that variations in surgical rates result mainly from differences in physicians' "style of practice." However, other factors such as the incidence of disease and the health status of the population could be responsible for the observed differences in surgical rates. In other studies of health status, the age and sex distribution of the population has been found to be a good proxy for these disease and health status variables. Accordingly, we have adjusted our surgical data for differences in age and sex.⁴

The distribution of surgical rates among the MSAs did not change significantly after the age and sex adjustments were made. Marietta, Toledo, Akron, Youngstown-Warren, Dayton-Springfield and Steubenville still recorded much higher rates than other MSAs.

Again, the highest average rate was

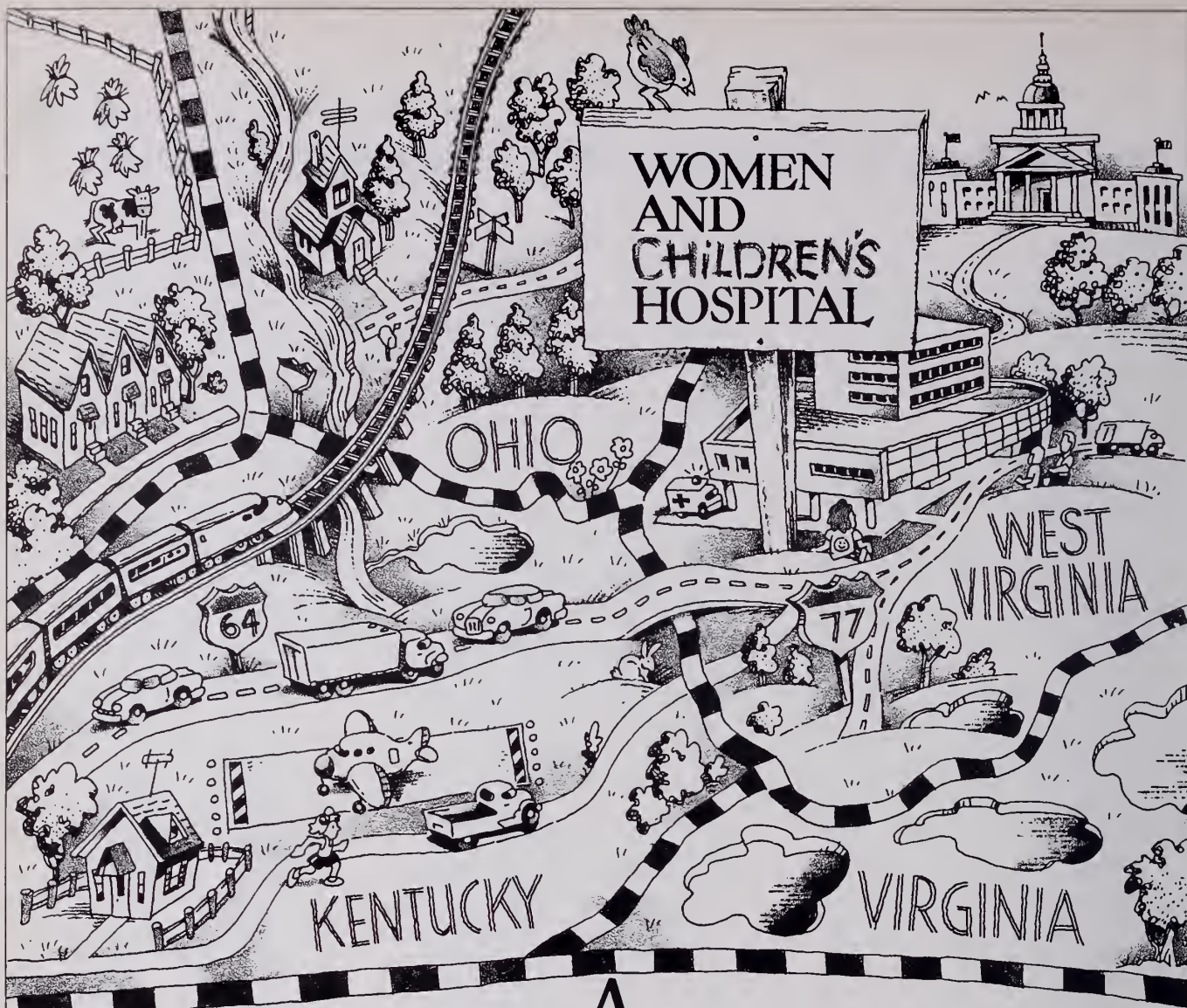
continued on page 575

TABLE 1**Variations in Surgical Rates Among Counties**

(Average Rate for Four Years F.Y. 1982-F.Y. 1985)

	Total		Tuscarawas	825	265
Rural Areas*	Surgeries	Avg. Rate	Van Wert	177	257
Adams	336	155	Vinton	106	143
Ashland	226	183	Wayne	438	174
Ashtabula	1,245	243	Williams	351	320
Athens	632	215	Wyandot	107	173
Brown	240	146	Total	22,629	235
Crawford	596	292			
Champaign	391	291			
Clinton	276	186			
Columbiana	1,034	277		Total	
Coshocton	545	215	Metro Areas*	Surgeries	Avg. Rate
Darke	504	291	Allen	1,058	203
Defiance	361	231	Auglaize	301	242
Erie	505	233	Belmont	595	156
Fayette	345	231	Butler	2,456	238
Gallia	355	198	Jefferson	1,274	303
Hancock	309	178	Carroll	215	206
Guernsey	395	186	Lawrence	1,170	230
Hardin	378	271	Lorain	2,285	208
Harrison	195	236	Richland	955	196
Henry	81	127	Stark	3,823	269
Highland	318	189	Washington	866	350
Hocking	389	258	Clark	2,184	282
Holmes	80	153	Clermont	846	175
Huron	318	172	Cuyahoga	15,727	216
Jackson	522	218	Delaware	271	223
Knox	579	316	Fairfield	618	223
Logan	409	239	Franklin	10,564	275
Marion	1,079	330	Fulton	162	199
Meigs	314	183	Geauga	141	187
Mercer	196	206	Greene	1,022	277
Monroe	129	179	Hamilton	5,409	146
Morgan	189	219	Lake	609	188
Morrow	336	288	Licking	1,019	218
Muskingum	580	154	Lucas	7,292	297
Noble	86	181	Madison	314	265
Ottawa	270	285	Mahoning	4,572	303
Paulding	144	201	Medina	468	244
Perry	254	141	Miami	718	285
Pike	540	256	Montgomery	6,239	248
Preble	390	254	Pickaway	522	260
Putnam	106	140	Portage	1,345	310
Ross	789	260	Summit	6,273	298
Sandusky	681	359	Trumbull	2,973	320
Scioto	2,333	334	Union	268	291
Seneca	356	168	Warren	704	229
Shelby	389	217	Wood	500	228
			Total	85,758	241

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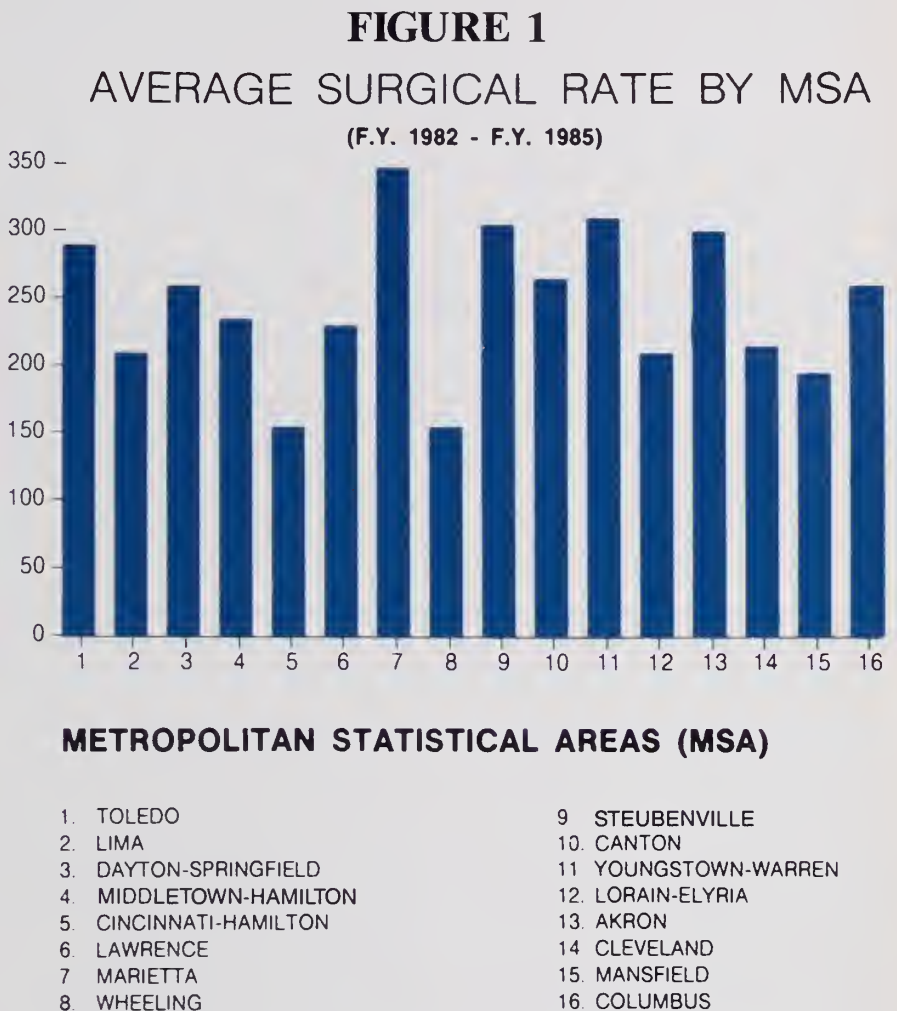
found in Marietta and the lowest in Wheeling. Thus, even when relevant demographic factors are taken into consideration, there are still dramatic variations in the surgical rates of different metropolitan areas across the state.

Finally, we also looked at the rates for individual surgeries within the MSAs. The data clearly indicated that some surgical procedures showed greater variation than others. For example, the rate of hernia repair varied less than the tonsillectomy rate, while the meniscectomy rates varied much more than the rate for cataract extraction. Despite this variation between surgical procedures, these rates did not vary over time. In other words, an MSA with a high number of hysterectomies in 1982 also had high hysterectomy rates in 1983, 1984 and 1985.

Conclusion

The information presented in this report can serve as a valuable education tool. ODHS believes that most physicians do not know that such wide variations exist in surgical practice. Given the information about how their own practices compare with those of their colleagues statewide, as well as in other geographic locations, physicians can re-examine their practice patterns and alter their style if necessary.⁴ They can also help the department to explain some of the observed variations by identifying inappropriate surgery where that is occurring. Finally, physicians can play a constructive role in lowering the incidence of elective surgeries through the use of medically appropriate alternative treatments whenever possible, without hurting the quality of care received by welfare recipients.

The Department has been working with the Ohio State Medical Association, the Ohio Osteopathic Association and the Ohio College of Surgeons to



explain the large surgery variations. The purpose of this joint effort is to save Medicaid recipients from unnecessary surgery and to control the increasing costs of the Medicaid program.

NOTES

1. Philip Caper, "Variations in Medical Practice: Implications for Health Policy," *Health Affairs*, Summer, 1984, pp. 111-119.
2. The patient can proceed with the surgery irrespective of the result of the second consultation. However, the state will not pay for the surgery, or will pay only part of the cost if the patient has failed to obtain the second opinion.
3. The 10 surgical procedures selected for the study are:

1. Hemorrhoidectomy
2. Hernia Repair
3. Hysterectomy
4. Tonsillectomy and Adenoidectomy
5. Meniscectomy
6. Cholecystectomy
7. Dilatation and Curretage
8. Prostatectomy
9. Rhinoplasty
10. Cataract Extraction
4. For each procedure, the numbers were divided by the age and sex cohort relevant for that procedure. For example, the number of tonsillectomies done was divided by the number of eligibles in the age group of six to 21.
5. Philip Caper and Michael Zubkoff, "Managing Medical Costs Through Small Area Analysis," *Business and Health*, Sept. 1984, pp. 20-25.

An American College of Surgeons Response to the ODHS Survey

By Richard B. Reiling, MD, FACS

The initial objective of the Ohio Department of Human Services (ODHS) in studying the incidence of surgical procedures (which is published in this issue of *OHIO Medicine*) was to provide the provider, namely the physician, with feedback on possible variations in surgical rates, but also to "... target cost management strategies." Both of these goals are in principle acceptable and understandable. After the data was obtained and analyzed, however, the objectives were restated retrospectively, "... to target the very high surgical rate counties where patients might be exposed to inappropriate surgeries; and target those very high surgical rate procedures which ought to be monitored and reviewed." The obvious variations that were demonstrated led to a more bold definition of objectives with the definite innuendo that a high incidence of surgical procedures is equated with inappropriate surgeries. Thus, in essence, the objective is now to reduce the

costs by monitoring and reviewing surgical procedures in counties where the rates exceed a "determined norm." Similar government fiscal agency studies have been done in other states and have also shown considerable variations in surgical procedures among small areas within the same state.^{1,2,3} The overwhelming conclusion, however, in all of these studies is that variations are not necessary and that conformance is an attainable and desirable goal.

With clear and obvious precedence the ODHS conducted the study and has demonstrated similar variations among counties within the state of Ohio, but more specifically among selected metropolitan areas within the state. Thus the large metropolitan communities of Cleveland, Columbus and Cincinnati are compared with the more urban-rural metropolitan areas of Marietta, Wheeling and Lima. The final draft of the study primarily deals with variations among the counties.

The ODHS certainly should be commended for seeking answers to these variations (from the providers) prior to releasing the data and recommending control measures, such as mandatory second opinion, preadmission certification, etc. The initial study was forwarded to the OSMA for advice and comment. The Ohio Chapter of the American College of Surgeons (Ohio-ACS) was in turn solicited for assistance. Both organizations, working together, were able to begin a cooperative dialogue with principals at ODHS to explain the variations.

By request, the ODHS was able to demonstrate that the results, which in many situations dealt with very small numbers of procedures, were statistically valid. At this time the ODHS is also trying to specifically identify the providers to which the variations may be ascribed. This latter task has proved to be more difficult than anticipated, but, nevertheless, the effort will continue in cooperation with the OSMA.

ODHS survey causes concern

The following is the news release issued by the OSMA at the ODHS press conference on Variations in Medicaid surgical rates.

The real problems that such studies present are not addressed in this nor many of the previous studies. It is clear that variations in medical and surgical care do exist and often are not related to the medical needs of the communities but to differences in medical practice. And often the mere fact that such variations are indeed identified, medical practices change to narrow the differences — a fact noted by ODHS and included in the study.

The assumption is usually made from these studies that more surgery obviously represents inappropriate or unnecessary surgery and thus is more expensive in terms of dollars and patient suffering. It is conceivable, on the other hand, that less surgery might in fact represent inadequate medical care and although conservative in cost, is very expensive in terms of health and discomfort. This very study does not address this issue but the Ohio-ACS and the OSMA are concerned that readjustment of rates to conform with the large metropolitan areas may well be detrimental to health-care delivery in the smaller urban-rural communities.

Since there is no comparison of the surgical rates with the utilization of other Medicaid services such as the incidence of obstetrical deliveries — a procedure that cannot be considered inappropriate — or the use of other welfare services such as food stamps, there is no way to be sure that the variations do not conform to the entire welfare use in a given community. This is an area in which the OSMA, Ohio-ACS, and the ODHS are now working.

The concept of “appropriateness of care” is not easy to define and must be considered in a community or local context. Dr. Francis D. Moore, professor

Richard B. Reiling, MD, FACS, immediate Past President of the Ohio Chapter of the American College of Surgeons, expressed concern over the results of a survey released by the Ohio Department of Human Services showing regional variations in the surgical rates for Medicaid patients.

“The study certainly seems to indicate that there are variations by region in the amount of surgery performed on Medicaid patients. While some variation would be normal, if the results of this survey are correct, then there may be areas of the state in which over-utilization of the Medicaid program is a problem,” Dr. Reiling said, adding that if this is true, the OSMA and the Ohio Chapter of ACS are very interested in working with ODHS to resolve the problem.

Dr. Reiling pointed out, however, that there were mitigating factors which could have influenced the results of the survey. For example:

- No “correct” level of surgical utilization has been established, therefore, Medicaid patients in a region that shows higher surgical rates could, in fact, be receiving appropriate care. In other words, since there is no standard against which to compare the results,

higher rates could be indicating appropriate care and lower rates could indicate under-utilization.

- In many areas of the state such a small number of Medicaid patients were studied that the actions of one hospital or even one physician could have been overemphasized in the results.

Despite these potential drawbacks to the study, Dr. Reiling stressed that the problem, in whatever magnitude, must be resolved.

“If there are physicians who are over-utilizing, we want to know who they are so that we can do something about it,” Dr. Reiling said. “Most experts agree that educating health-care providers about the problem can have a significant impact on utilization rates. If we can identify those physicians who the survey indicates are above the average and verify that they are, indeed, over-utilizing then we can educate them about the problem. I firmly believe that by doing this we can significantly lessen utilization rates,” Dr. Reiling said.

The Ohio Chapter of ACS and the OSMA have asked ODHS to provide them with this information so that they may begin the educational process.

emeritus at Harvard Medical School, in commenting on variations in small areas stated: “Searching out aberrant or ill-conceived medical practices is an important social mission. They are a likelihood in any variegated population seeking help from an equally mixed cohort of physicians. One must differentiate practice variability, potentially the result of ignorance or cupidity, from variability intrinsic to variable patient demands, treatment options, local cultural, ethnic, and economic imperatives.” Each community

must be evaluated in terms of epidemiology of disease as well as availability of care modalities. Medical care often is distributed in a complaint-response mode; for example, a factory worker does not seek medical care every time a pain in the chest is felt, whereas, a young executive is prone to seek such care more often. This variation in itself can often explain wide variations in medical care from community to community and must be considered in comparing coronary catheterization and bypass procedures. In a similar light, treatment options

among physicians are often acceptable and the only method to eliminate variability is the presence of a single treatment option. For example, there is only one reasonable treatment for an inguinal hernia, but many options for hemorrhoidal disease, and so on.^{6,7} Another concept often not considered in such studies is the age and training of the provider. Obviously, the large metropolitan communities with their teaching facilities are in the vanguard of medical care and tend to introduce new treatment modalities — not always, however, the best modalities. The mere fact of re-education and retraining, therefore, must be considered.

It is not the goal of the OSMA or the Ohio-ACS to underestimate the value of this study or ignore the variations that have been demonstrated. In truth there may well be some degree of overutilization of medical care in Medicaid patients which could well reflect patterns of care in other segments of the community. All of the organizations will continue to search for adequate answers for the variations. But, the individual choice of the physician to treat the patient in the manner considered best for the patient, and likewise the right of the patient to choose the practitioner of choice must be protected. Government and other fiscal agents must be advised when their policies run counter to good medical care. The OSMA and the Ohio-ACS will continue to work with any responsible fiscal intermediary to adequately explain real variations. On the other hand, physicians who dispense medical care unnecessarily or at exorbitant cost should not expect to be supported by their colleagues.

BIBLIOGRAPHY

1. Wennberg, J.E., Gittelsohn, A.: Health-Care Delivery in Maine I: Patterns of Use of Common



Elson-Alexandre, Los Angeles, CA.

Richard B. Reiling, MD

- Surgical Procedures. *Jour. Maine Med. Assoc.* 66:123, 1975.
2. Wennberg, J.E., Gittelsohn, A.: Variations in Medical Care among Small Areas. *Sci. Am.* 246:120, 1982.
3. Lewis, C.E.: Variations in the Incidence of Surgery. *N. Eng. Jour. Med.* 281:880, 1969.
4. Caper, P.: Managing Medical Costs Through Small-Area Analysis. *Bus. Health.* 1984 Sep. 1(9):20, 1984.
5. Moore, F.D.: Small-Area Variation Studies: Illuminating Or Misleading? [commentary]. *Health Aff.* 1985 Winter. 4:96, 1985.
6. Moore, F.D.: Small-Area Variations in Health-Care Delivery. A Critique. *Jour. Maine Med. Assoc.* 68:49, 1977.
7. Caper, P.: In Defense of Small-Area Analysis [letter]. *Health Aff.* 1985 Winter. 4:115, 1985.

Richard B. Reiling, MD, FACS, immediate past president of the Ohio Chapter, American College of Surgeons, spoke on behalf of the ACS and the OSMA at a recent press conference called by ODHS.

OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

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INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

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WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both additional medication, parenterally administered, and close monitoring, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function, 2) patients over 55 years of age, particularly males and those with chronic lung disease, 3) those with cardiac failure from any cause, 4) neonates, and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient, when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently, serious toxicity is not reliably preceded by less severe side effects.

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (monkeys, rodents and dogs) when theophylline and beta agonists were administered concomitantly, not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the GI tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with epinephrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR 200, 300, and 450 mg Sustained Action Tablets. The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered:

1. Every 24 hours in children under 12 years of age, have not been established.
2. Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

1. Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.
2. Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.
4. Respiratory: tachypnea.
5. Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.
6. Other: rash, hypoglycemia and inappropriate ADH syndrome.

OVERDOSE/Management: If potential oral overdose is established and seizure has not occurred:

- A. Induce vomiting.
- B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken).
- C. Administer activated charcoal.
- If patient is having a seizure:
 - A. Establish an airway.
 - B. Administer oxygen.
 - C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
 - D. Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Care:

- A. Maintain airway and oxygenation.
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis, however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert. Revised 6/87

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ASK THE OMBUDSMAN . . .

Q. *The Ohio Medicaid program has denied my patient a brand name prescription drug which I have prescribed. This patient should not take any generic equivalent because of a possible anti-convulsive reaction. The state should not be allowed to practice medicine. Can the OSMA correct this problem?*

— MD, Columbus

A. The Ohio Revised Code deals with this issue as such: "Unless instructed otherwise by the person receiving the drug pursuant to the prescription, a pharmacist filling a prescription for a drug prescribed by its brand name may select a generically equivalent drug . . . subject to the following conditions:

1. The pharmacist shall not select a generically equivalent drug if the prescriber handwrites "dispense as written" or "D.A.W." on the written prescription, or, when ordering a prescription orally, the prescriber specifies that the prescribed drug is medically necessary. These designations shall not be preprinted or stamped on the prescription.

2. The pharmacist shall not select a generically equivalent drug unless its price to the purchaser is less than the price of the prescribed drug, and shall pass on as a savings to the purchaser, other than the State Medical Assistance program, the full amount of the retail price difference between the prescribed brand name drug and the generically equivalent drug. The amount paid for the generic drug under the State Medical Assistance program shall be as provided by federal regulation.

3. The pharmacist, or the pharmacist's agent, assistant, or employee shall inform the person receiving the drug pursuant to the prescription of the selection of a lower cost generically equivalent drug, of the price difference between the brand name drug and the generically equivalent drug, and of the person's right to refuse the drug selected." ORC 4729.38 (A)

— OSMA Ombudsman

Office Medical Records: A Key Element in Protection

All doctors recognize the importance of accurate and complete medical records. Yet in the increasingly complex atmosphere of today's medical office, a constant effort must be made to avoid the occasional lapses that can create problems of magnitude — and perhaps play a part in a future medical professional liability claim.

Our recommendation is a regular evaluation of record-keeping practices, conducted on an objective basis by the physician (and not by a member of the staff). Following are some suggestions you may find helpful.

Office Charting Procedures

Notations of appointments which are missed or cancelled — and the reason if known — are important additions to the patient chart, along with notations from all telephone conversations regarding patient care, whether with the physician or a staff member.

Chart notes need to be readable, signed and dated. Corrections and additions should be entered chronologically, then signed and dated. In the physician's absence, a colleague should be able to use the information from the medical chart to provide patients with immediate and appropriate care.

Patient Workup

The patient's chart should include past medical history, drug allergies, past medical treatments, current medications and family medical history. When you chart the reason for the office visit — including all of the patient's current complaints — you also may have the patient complete a

Chart notes need to be readable, signed and dated.

questionnaire on which you can document your review and follow-up. Document your investigation of question marks and blank spaces which the patient may leave on the questionnaire.

Diagnosis

Chart data you have used to support your diagnostic impressions. Review and initial all lab, pathology and X-ray reports before placement in the chart. Chart discussions with other providers that lead to your diagnosis.

Treatment and Follow-up

Be certain that the treatment

plan, as outlined, is supported by findings in the workup and diagnosis. Chart the patient's informed consent and, when appropriate, informed refusal. When charting your instructions to the patient, include: who is responsible for follow-up (patient or physician); recommendations for referral to outside care; consideration of previous findings in follow-up; review of subsequent lab or X-ray reports; and the patient's compliance or non-compliance with recommendations.

You may want to select several office records which contain recent entries to see if the suggestions described above are reflected.

This exercise can help you determine where your office's medical record-keeping strengths and weaknesses may be — and then to take appropriate action. In today's legal climate, shortcomings or deficiencies involving any of the items we have discussed could possibly expose you to liability. **OSMA**

Prepared as a project of the sub-committee on Loss Awareness, with the assistance of PICO staff and the Oregon State Medical Association.

DIAGNOSING DEATH IN THE STATE OF OHIO

John H. Coleman, MD

Practicing physicians and resident hospital staff frequently need guidance and updating in making the diagnosis of death. Since this diagnosis is as legally obligatory as in any other disease state in medicine, hospital administrators also are concerned with the quality and appropriateness of the diagnosis. Death in the adult is discussed in this paper utilizing the parameters recommended by the Uniform Acts and the most current guidelines available to the state of Ohio.

Introduction

Resident house staff and practicing physicians alike are frequently required to establish the diagnosis of death. Usually this diagnosis is made without difficulty and quite reliably. Occasionally, difficulties may arise when the traditional cardiopulmonary parameters of death may not reflect "brain death." Since diagnosing death is of such obvious importance, the medical standards a physician uses to establish death are extremely important. The criteria for determining death are now as well defined as any other diagnosis in medicine (subject, however, to the changing parameters of a highly technologic medical science).

Some physicians confuse the diagnosis of death with other issues of dying such as euthanasia and "living wills." These concerns should not be confused with establishing the strict diagnosis of death in the adult patient. It should also be recognized that fetal death and death in children require a somewhat different set of guidelines for making the diagnosis than death in the adult. Physicians having the obligation medically and legally to make the diagnosis of death, moreover, should likewise not confuse the diagnostic parameters for death with concerns about patients in the "vegetative state" and decisions regarding which patients should have cardiopulmonary support withheld.

Legally the diagnosis of death should also not concern itself with the viability of organs as the result of sufficient or sustaining peripheral circulation. Concerns about death with dignity, rules on death certificates, maintaining life support beyond brain death in cases of pregnant women, and protection accorded the

dead body, moreover, should also not be factors which are considered at the point of making the diagnosis of death.¹

The physician should understand that the diagnosis of death in a patient implies that further therapy of any kind will not yield a living, sentient person. This paper will attempt to define the legal and medical parameters for making the diagnosis of death as well as outline algorithmically the steps to be utilized in the diagnosis.

The physician must recognize that the most fundamental distinction between determining the state of death and allowing to die is that a declaration of death is obligatory while the decision to allow to die is permissive.²

"It remains for the Doctor . . . to give a clear and precise definition of 'death' and the 'moment of death' of a patient who passes away in a state of unconsciousness." (Pope Pius XII — 1958).

Background

With the advent of cardiopulmonary support, the diagnosis of death based on these two interrelated organ systems is precluded, requiring that the diagnosis be based on neurological criteria to determine that the brain including the brain stem functions has irreversibly ceased. This requirement shifts the focus of the clinician and the public from the traditional belief that the heart and lungs, exclusively, represent the seat of life. The new criteria for death makes the legal and medical professions recognize that the brain and the person are indeed one. This concept has been well established in the Uniform Brain Death Act (1978),¹ later superseded by the Uniform Determination of Death Act (1980). The Act, however, is silent on acceptable diagnostic tests and medical procedures. The medical profession remained free to formulate acceptable medical practices employing new biomedical knowledge, diagnostic tests and equipment.³

Physicians should be familiar with local guidelines and state law concerning diagnosing death. With legal guidance suggested by the Uniform Determination of Death Act, several state regulations have been adopted. For our discussion the criteria for the determination of death will be those utilized in the state of Ohio. This is not to imply that specific features outlined in this discussion will not suffice to establish the diagnosis of death in other states.

Although considerable effort has been made to firmly establish legal uniformity, medical criteria for death as suggested by the medical consultants to the President's Commission⁴ are modified by major complicating and reversible conditions. Physicians must be cognizant of these conditions in making the diagnosis of death in order to firmly establish that further treatment will not produce a living, sentient person. These very

John H. Coleman, MD, is a member of the inpatient teaching faculty at Mercy Hospital Family Practice Residency in Toledo.

important conditions are drug and metabolic intoxication, neuromuscular blockade, hypothermia, young age and shock.

Legal Criteria

Local Guidelines

Hospitals in Ohio have attempted to define the staff physician's role in making the diagnosis of death. For example, the Toledo Mercy Hospital in 1976 described the hospital's policy on death and dying: "At the present time physicians are the best trained persons to ascertain the condition of death. It is the policy of this hospital that the attending physician of a patient, with or without use of variously available aids or tests or consultations with other physicians, be the appropriate person to make the determination of the condition of death, or its practiced equivalent, the absence of human life."⁵

A National Uniform Death Act

During the 1970s, beginning with Kansas, 25 states enacted brain death legislation. The language of the statutes was not uniform from state to state and the diversity of proposed and enacted laws created substantial confusion. Consequently, the American Bar Association, the American Medical Association, the National Conference of Commissioners on Uniform State Laws, and the President's Commission for the Study of Ethical Problems in Medicine, Biomedical and Behavioral Research proposed a model statute intended for adoption in every jurisdiction. (A uniform act is a set of guidelines that has been developed by a commission of nonpartisan experts to provide a model intended for adoption by local, state or national jurisdictions.) As a result of the Commission's activity the Uniform Determination of Death Act was approved by the National Conference of Commissioners on Uniform State Laws in August 1980:

"An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."⁶

This wording has also been endorsed by the American Academy of Neurology and the American Electroencephalographic Society.

Ohio Legislation

The state of Ohio, in adopting the model of the Act, developed Section 2108.30 of the Ohio Revised Code to Define Death which became effective March 15, 1982:

"An individual is dead if he has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards. If the respiratory and circulatory functions of a person are being artificially sustained, under accepted medical standards a determination that death has occurred is made by a physician by observing and conducting a test to determine that the irreversible cessation of all functions of the brain has occurred.

"A physician who makes a determination of death in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts or the acts of others based on that determination.

"Any person who acts in good faith in reliance on a determination of death made by a physician in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceedings for his actions."⁶

**Editor's Note: It should be noted that the legislation permits the physician to choose medically appropriate test or tests to establish death. It does not require the utilization of a specific test or tests. The legislation was intended to give the physician the ability to choose the best test or tests from among those available at his or her facility.*

Medical Criteria

The report of the group of 57 medical consultants to the President's Commission presented a distillation of current practice in the determination of death including their estimation of the most commonly available and verified tests. Their guidelines will be discussed to determine the irreversible cessation of life.

Cardiopulmonary Cessation

The group of medical consultants stated that cessation could be recognized by brief appropriate examination which included the absence of responsiveness, and of heart and respiratory effort. A confirmatory test such as an EKG could be used to establish cessation.

Cardiopulmonary Irreversibility

Irreversibility is established during an appropriate period of observation and/or trial of therapy and might take only a few minutes if death has been expected. Likewise if there is no intention to resuscitate, irreversibility is apparent in a monitored patient who develops fibrillation and standstill. In the latter instance the required period of observation may again only be a few minutes. The immediate determination of the irreversible cessation of cardiopulmonary function can be established in an individual who when first observed has rigor mortis or putrefaction. Possible death, however, unobserved, unexpected or sudden, requires more detailed and repeated examination over a longer period of time while resuscitative efforts are undertaken as a test of cardiovascular responsiveness.

Cessation of Brain and Brain Stem Function

When a patient is being artificially maintained by cardiopulmonary support, it is imperative that irreversible cessation of all functions of the entire brain including the brain stem be determined in order to establish the diagnosis of death.

The functions of the entire brain that are relevant to the diagnosis of death must be clinically ascertainable and subject to confirmation. The attending physician may wish at some point to consult with another physician more experienced in the laboratory techniques and neurological examinations necessary to determine irreversibility. Certain clinical maneuvers, however, may be used to establish cessation of brain function, when these functions are absent in the case of deep coma, cerebral unresponsiveness and unresponsivity. These maneuvers include the determination of pupillary light reflex, corneal reflexes and oculocephalic/oculovestibular reflexes. Absence of other reflexes are also helpful in determining the loss of brain stem functions. These include oropharyngeal, respiratory, cochleopalpebral, jaw reflex (masseteric) and glabellar reflexes. There should also be no response to ice water caloric testing which consists of nystagmus produced by irrigating each unobstructed external auditory canal with 50 cc of ice water (oculovestibular reflex).

Summary

Suspected Death
(Adult)

Patient being given
ventilatory support

In a patient without
ventilatory support

Cessation of heart and lung function. (Presumptive Death)

CRITERIA: EKG,
Absence of responsiveness and pupillary/CNS reflexes.

- a) Irreversibility (Observed)
CRITERIA: Death expected — monitored, dysrhythmia or absence of cardiac activity.
- b) Irreversibility (unobserved, sudden)
CRITERIA: Rigor mortis, putrefaction, unresponsive to basic and advanced cardiopulmonary resuscitation.
- c) Reversible causes of coma
 - Sedation and drug intoxication
 - Metabolic Intoxication
 - Hypothermia
 - Neuromuscular blockade
 - Shock
 - Young age

Cessation of heart and lung function. (Presumptive Death)

CRITERIA: EKG,
Absence of responsiveness, pupillary reflexes and other CNS reflexes — light, corneal, oculocephalic/oculovestibular, oropharyngeal, respiratory, cochleopalpebral, jaw and glabellar. No response to caloric testing and apnea testing.

- a) Irreversibility
 1. Cause of coma established.
 - History
 - Clinical exam
 2. Appropriate period of observation — (12-24 hours) when confirmatory tests not available.
 3. CT Scan
 - Temperature (core)
 - Drug screen
 - Base line EEG
 - Angiography
 - Radionuclide studies
- b) Reversible causes of coma
 - Sedation and drug intoxication
 - Metabolic Intoxication
 - Hypothermia
 - Neuromuscular blockade
 - Shock
 - Young age

Apnea testing is an important and often pivotal confirmatory test used to determine the absence of brain stem function. The procedure begins with ventilation of the patient with 100 percent oxygen for 10 minutes. This is followed by the passive flow of 100 percent oxygen usually through a tube directed into the hypopharynx or trachea. A 10-minute period of apnea following these procedures is sufficient to attain a hypercarbia of greater than 60 mmHg which will adequately stimulate respiratory effort, usually in 30 seconds. Resultant spontaneous breathing efforts would indicate that part of the brain stem is functioning.⁷ Some investigators would suggest additional features be added to the protocol including increasing the preoxygenation period to 30 minutes, requiring the PaCO₂ to be at least 36 mmHg and the arterial P.H. be 7.44 or less before disconnecting the ventilator to test the respiratory response to subsequent apnea/hypercarbia.⁸

Although peripheral nervous system activity and spinal cord reflexes *may persist after death*, true decerebrate or decorticate posturing or seizures are inconsistent with the diagnosis of death.

Brain and Brain Stem Function Irreversibility

Irreversible cessation of functions of the entire brain is determined when, 1) the cause of the coma is established, 2) when the possibility of recovery of any brain function is excluded and 3) when cessation of all brain functions persist for an appropriate period of observation and/or trial of therapy.

The cause of coma can be established by careful clinical

examination and investigation of the history of the patient upon whom the diagnosis of death is being made. A CT scan, core temperature, drug screening, and electroencephalography may be used during the period of observation to assist with establishing the reason for the coma. Other procedures including angiography and radionuclide scan procedures may also assist in determining the cause of coma.

In the adult patient, sedation, metabolic intoxication, hypothermia, neuromuscular blockade and shock are extremely important reversible conditions and must be excluded in order to firmly establish the irreversible nature of the cessation of brain function. Brain blood flow studies may, in fact, be needed in these special reversible situations to demonstrate whether there exists a sufficient and irreversible condition.

In the consultants' report there were no cases in which brain function returned following a six-hour cessation, documented by clinical examination and EEG except *drug intoxication, hypothermia, young age or shock*. When faced with these four exceptions it is incumbent upon the examiner, especially if confirmatory tests are not available, to allow a period of observation of at least 12 hours to elapse. A 24-hour observation period is generally desirable to determine irreversibility in the case of anoxic brain damage when confirmatory tests are unavailable.

Except in patients with *drug intoxication* or *hypothermia*, electrocerebral silence verifies the irreversible loss of cortical functions. The American EEG Society's Ad Hoc Committee on EEG Criteria for the Determination of Cerebral Death in the

late 1960s reported that only three patients out of 2,650 cases of coma with isoelectric EEGs showed any recovery of cerebral function. These three patients had suffered from *massive overdoses of central nervous system depressants* — two from barbiturates and one from meprobamate. Since the isoelectric and flat records in review were due to either low-voltage recordings or performed with techniques inadequate to bring out low-voltage activity, the term *electrocerebral silence* was adopted to replace the previous terms. *Electrocerebral silence* by definition is *no electrocerebral activity*. In order to avoid inadequate techniques, therefore, the American EEG Society adopted 12 recommendations for diagnosing cerebral death:

1. A minimum of eight scalp electrodes and earlobe reference electrodes.
2. Interelectrode impedances under 10,000 ohms but over 100 ohms.
3. Integrity test of the entire recording system.
4. Interelectrode distances of at least 10 centimeters.
5. Sensitivity from 7 (7.5)mV/mm to 2mV/mm during most of the recording with inclusion of appropriate calibrations.
6. Use of time constants of 0.3 to 0.4 seconds during part of the recording.
7. Use of monitoring techniques.
8. Test for EEG reactivity to intense stimuli such as pain (e.g., pinch), loud sound, and (optionally) strong light (stroboscopic if available).
9. Recording time of at least 30 minutes.
10. Recordings to be made only by a qualified technologist.
11. A repeat EEG if there is doubt about electrocerebral silence.
12. Telephone transmission of EEG not to be used for determination of electrocerebral silence.

In cases where reversible conditions are suspected confirmatory tests other than the EEG may be used, these include four-vessel intracranial angiography, radioisotope bolus cerebral angiography, and gamma camera imaging with radioisotope cerebral angiography. Without (technically) complicating conditions, absent cerebral blood flow as measured by these tests, in conjunction with clinical determination of cessation of all brain functions for at least six hours, is diagnostic of death.

Complicating Conditions Which Modify the Uniform Criteria for Death

Although the diagnosis of death may be established in the great majority of cases utilizing the examinations and laboratory procedures described, there are several complicating conditions⁴ which may alter the accuracy and therefore the criteria for the determination of death. Four of these conditions have been mentioned previously — drug intoxication, hypothermia, young age and shock — to which will be added metabolic intoxication.

Drug Intoxication

Cessation of brain functions caused by the sedative and anesthetic drugs, such as barbiturates, benzodiazepines, meprobamate, methaqualone and trichlorethylene, *may be completely reversible* even if they have produced clinical cessation of brain functions and electrocerebral silence. Toxicologic screening for all likely drugs is mandatory. If exogenous intoxication is found, *death may not be declared until the intoxicant is metabolized or until intracranial circulation is tested and found to have ceased*.

The examining physician should also be aware that total paralysis produced by such neuromuscular blocking agents as

aminoglycoside antibiotics and diseases like myasthenia gravis may produce total paralysis and cause unresponsiveness, areflexia and apnea. Prolonged paralysis which may give the appearance of death after the use of succinylcholine and related drugs requires evaluation for pseudo-cholinesterase deficiency. The EEG may, in fact, be an important instrument to evaluate drug-induced coma since electrocerebral activity may return or persist while the patient remains unresponsive. Short latency auditory or somatosensory-evoked potentials may be used to test brain stem functions in the case of drug intoxication, since these neurologic potentials are unlikely to be affected by drugs.

Metabolic Intoxication

Severe illnesses which can cause coma including hepatic encephalopathy, hyperosmolar coma and pre-terminal uremia should be corrected if at all possible before irreversible cessation of brain functions is declared.

Hypothermia

Criteria are not available for the determination of brain death in the presence of hypothermia below a core temperature of 92.2°F (33.4°C). Although hypothermia is not a common cause of difficulty in the determination of death this state can mimic brain death by altering ordinary clinical criteria and can protect against neurologic damage due to anoxia. If it is unclear whether an individual is alive, the only available measure to resolve the issue is to *restore the person to normal temperature*.

Children

The brains of infants and young children, especially children less than five years old, have *increased resistance to damage* and may recover substantial functions even after exhibiting unresponsiveness on neurological examination for longer periods than adults.

Shock

Due to the reduction in cerebral circulation caution should also be used in applying the neurologic criteria to patients in shock since this condition can render clinical examination and laboratory tests unreliable.

REFERENCES

1. *Uniform Determination of Death Act*. Approved by National Conference of Commissioners on Uniform State Laws — August 1980.
2. Ethics Committee of the American Academy of Neurology. Cranford, Ronald E., M.D., Beresford, et al. "Uniform Determination of Death Act." *Connecticut Medicine* 1982 May. Vol. 46, No. 5: 259-260.
3. Page's Ohio Rev. Code ANN, 2108.30 [Death defined] pp. 32.
4. Report of the medical consultants on the diagnosis of death to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. "Guidelines for the Determination of Death." *Connecticut Medicine* 1982 Apr. Vol. 46, No. 4:207-210.
5. Mercy Hospital Policy. "Guidelines for Determination of Death." *Mercy Hospital Staff Minutes*, 7/76.
6. General Assembly of the State of Ohio. (Amended Senate Bill No. 98) *An Act* 1982 Apr. Section 2108.30.
7. Plum, Fred, and Jerome B. Posner. *The Diagnosis of Stupor and Coma*. Edition 3. F.A. Davis Co., Philadelphia. 1980.
8. Belsh, JM, Blatt, R, Schiffman, PL. "Apnea Testing in Brain Death." *Arch Intern Med* 1986, 146:2385-8.
9. Bennet, DR, Hughes, JR, et al. *An Atlas of Electroencephalography in Coma and Cerebral Death*. Raven Press, 1976, pp. 35-40.

COMBINING PSYCHOTHERAPY AND PSYCHOCHEMOTHERAPY

Theodor Bonstedt, MD
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It is increasingly common for a physician — often other than a psychiatrist — to prescribe psychiatric medication for a person who at the same time receives psychotherapy (counseling) from a trained mental health professional. This requires close cooperation and an ongoing exchange of information between the two professionals. This paper outlines experience obtained in such combined treatment, listing indications, advantages and disadvantages. Since medication and social skills training are both necessary for optimal rehabilitation of psychiatric patients, there will be an increasing need for coordination of psychotherapy and psychochemotherapy.

Introduction

A type of treatment indicated in the title of this paper is becoming ever more prevalent, with psychotherapy being increasingly done by a person other than a psychiatrist or any physician in general, while the psychochemotherapy may often be done by a psychiatrist, but probably quite as often will be

done by physicians other than psychiatrists. Both in private settings and in community mental health centers, psychotherapy (usually then called simply "counseling") is done by psychologists, social workers, psychiatric nurses, vocational rehabilitation counselors, specially-trained ministers, activity therapists, etc. This development has been accelerating and at the same time, there has been an acceleration of psychiatric medications, the supervision of which requires obviously considerable amount of skill, if it is to be done properly. Surprisingly then, little has been published on the subject of coordinating psychotherapy and psychochemotherapy in those situations where each of the treatment modalities is performed by a different person, these two professionals hopefully being in a sufficient kind of contact. A recent good book on the subject attracted the attention of the writers¹ who are employed by a mental health center where psychiatrists' work indeed consists primarily of overseeing psychochemotherapy and then consulting with other professionals from that point of view. The purpose of this paper is to give a practical overview of what the present state of the art in this field may be. The definition of psychotherapy used in this paper is a conventional textbook one:^{2,3} alleviation of emotional disturbance through a professional contract and relationship with a trained person who makes therapeutic communication. The psychochemotherapy would mean prescription and medical supervision of medications influencing psychosis, excessive agitation, crippling anxiety or panic, and disabling depression.

General Considerations

In all types of psychotherapy one may discern several stages (engagement, pattern search, change and termination), and issues surrounding psychiatric medication may vary, depending on the stage of therapy. For instance, in the initial stage of engagement, medication which offers immediate symptomatic

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improvement (particularly if the improvement is in a type of cognition that facilitates logical conversation) may be particularly desirable and even enabling as far as psychotherapy.⁴

At the present time, there are fortunately fewer ideological battles between different schools of therapy, the attitudes generally are becoming more eclectic in planning treatment: this in turn makes it easier to combine psychotherapy and psychiatric medication. Both approaches in turn have been questioned about their effectiveness and even about alleged damage done to people who are "brain-washed" or "made into zombies."

Consequently, it becomes ever more important to know the feelings or attitudes of a particular person toward psychiatric medication (or medication in general) as such may be considered for him or her. The same is true of any immediate family of such a person. One may need to explain that psychiatric medication — if appropriately selected — may facilitate accessibility of a particular patient to therapy, may improve the psychological functions required for participation in such therapy and may promote the ability to share feelings. Therein may lie one of the risks, in that people who feel better upon taking medication may discontinue psychotherapy and in doing so, may avoid a source of necessary learning. Other factors in this reciprocal relationship include the manner in which psychotherapy may aid in rehabilitation of a person who is recovering from acute symptoms (such as panic attacks) with psychiatric medication — and while recovering, still needs unlearning of previous anxious habits. If the therapy/medication team works properly, therapy may facilitate compliance with medication. The risk in turn may be that the prescribing physician will see psychotherapy as unnecessary in light of the progress achieved in chemotherapy. At various levels then, there is the opportunity for varying integration of organic and psychological treatment factors — an integration that generally has remained elusive.

When use of medication is explained to the patient, the manner of such an explanation has to be based in part on the known personality of the patient:^{1, 5} for instance, the person with histrionic features will need a more global explanation of side effects, while an obsessive patient will need a thorough-going explanation. A psychotic person — especially in the beginning — may need a dependent parent/child relationship which will later change only gradually to greater autonomy as improvement takes place. Some paranoid patients insist upon retaining their own autonomy as they see it, and accommodation can be tried successfully when the patient is allowed to, e.g., use 24 mg of Trilafon at bedtime as a regular dose, but take one more 8 mg tablet at such a time on a particularly stressful day or when feeling sleepless. The doctor here may lose some of the precise measurement of the situation, but may gain a more compliant patient. People who are expecting the worst outcome from any medication and seem to defeat all approaches may be told at the beginning of a new medication that the doctor himself is skeptical as certain specified side effects may indeed occur — but the doctor is willing to prescribe it if the patient is willing to try it; with this approach, the patient may once again defeat the doctor's expectations, i.e., get along with the medication after all.

For a long time, various psychiatrists would state, tongue in cheek, "let's try this new medication, which has just come out, while it still works": this reflects upon the clinical fact that the prescribing physician better have a reasonable degree of belief in the effectiveness of the medication he prescribes, other-

wise success is less likely to come. The outcome here is presumably motivated through primarily non-verbal channels of the doctor's own behavior in dealing with this issue. In any case, it is important to reach an agreement concerning medication treatment at the outset, and then renegotiate such an agreement for the purpose of maintenance, as such maintenance medication typically has to take place after acute treatment of psychosis or depression has succeeded in stabilizing the patient. As part of the initial discussions, the risk of tardive dyskinesia has to be mentioned. Where a supportive family is available, they of course should be involved. The main task is to define, along with the family, behavior which would assist or support the patient's receiving medication, without completely taking over control and denying all autonomy (although the latter may have to be done in special cases). It has been reported that dosages of psychiatric medication have to be higher (other things being equal) in families with highly expressed emotions, and gross hostility or disrespect certainly would not be allowed by the therapist or doctor in meetings where medications are discussed. Where couples are seen in therapy and one partner is asked to see a physician for a psychiatric prescription, it may be advisable to see both partners, to avoid awkward confidences and to dispel common myths about medications being "a crutch" or making people "weak," also to discourage controlling the partner by playing the game of psychiatry. ("Now don't get angry with me — remember your psychiatrist told you that you could break down again.")

If medication is introduced during psychotherapy, it has to be treated as any other therapeutic intervention, which could have positive or negative effects upon the therapy, and open discussion in psychotherapy would apply here as with any other factors. It is made easier when the physician (typically a psychiatrist) does his own psychotherapy. At what point does pure activity of prescribing also become psychotherapy? Some authors¹ draw a line at contacts which are more than 30 minutes a month, where a psychiatrist or a physician functioning as a family doctor would inevitably begin to touch upon areas other than strict prescribing.

The Treatment Triangle

The treatment triangle consists of the patient, the psychotherapist or counselor (any one of a number of mental health professionals presently functioning in that role) and the physician (psychiatrist or otherwise). The longer the two professionals work with each other in these "triangles," the more comfortable they become with each other and probably the more likely they are to succeed. When is it essential to have a fully trained psychiatrist on such a team? In practice, there are many situations where a family physician (general practitioner, internist) may be the only one willing and able to fill this role. It has been repeatedly observed that little is known about the behavior of physicians who do aspects of psychiatric treatment in some type of general or specialist practice — presumably, they use a lot of common sense and advice, and apply support as best they can. The same patient may be seen also by an independent therapist, perhaps once a week, perhaps less, in a different part of town. We do not know of any rule to apply here,⁶ but it would seem to be an appropriate rule of thumb that the patient who needed psychiatric hospitalization should have a psychiatrist on the "treatment triangle" rather than another physician. It is true that many chronic patients, such as those on maintenance

anti-psychotic medication, seem to have fallen into a routine that does not allow much innovation or change for the prescribing psychiatrist; yet new approaches in rehabilitation through social skill training and vocational training are constantly being tried and the physician who does not have specialized training in psychiatry will have a problem in fitting his chemotherapy in the best way possible in the overall treatment. At the very least, he or she should obtain psychiatric consultation from time to time.

Once the therapeutic team has come about, it is very essential that both professionals have quick access to each other in case of need, and beyond that, apprise each other of progress in their assigned responsibility with their particular patient from time to time. Ideally, they should know some basics about each other's work, and should have either a similar understanding or theory of the process affecting the patient, or at least tolerate each other's point of view. They certainly should not criticize each other in front of the patient. That would encourage the patient to adhere to the other professional's appointments in spite of inevitable frustrations — best to bring those frustrations in the open. Ideally, a patient should know that two professionals will exchange information from time to time in his or her interests (in private practice, if there is a fee mechanism involved to provide for their professional time, that should also be explained beforehand). If emergencies come up, patients should be permitted to contact either therapist.

Special Considerations

Depression is probably the illness that most often is first treated in a family doctor's office; it seems to be becoming ever more prevalent. There are a lot of "grey areas" at the present as to when medication is to be used and when and what type of counseling becomes necessary. It's reasonable to see medication as unavoidable when there are symptoms of vegetative type — significant impairment of sleep, appetite and capacity for enjoyment of life — tricyclic anti-depressants or MAO inhibitors may then be tried. With symptomatic improvement, one may gradually attempt to discontinue such medication after six months or so, but there may be a lot of "depressogenic" attitudes left (essentially neurotic preoccupations that certain things have to be just so, or it is a catastrophe). Medications may or may not change such type of thinking and so psychotherapy may be advisable, and will be better tolerated after the initial or acute phase of depression. The type of psychotherapy that is presently best known for this purpose is cognitive therapy where the therapist examines conscious attitudes or thoughts or beliefs of the patient and attempts to restructure them by open analysis, tracing the irrationality, prescribing homework, etc. Along this line, we have learned that no matter how limited the time available in a public agency may be, two questions can be given as "homework" to inpatients or outpatients: one is "take time to write your life story" (which is then discussed, to elucidate the various irrational preoccupations). The other is: "What will you do differently in the future, to avoid this type of problem and breakdown and to cope better?" One has to be very specific in rehearsing, as it were, behaviors that will apply in dealing with people close to the patient, and one uses knowledge of events that brought the patient into therapy in the first place. Studies have shown that with selected populations of depressed patients, cognitive therapy produced as good results as anti-depressant medications. Where depression does not in-

volve many vegetative features, it may be diagnosed as non-endogenous (compare to "Dysthymic Disorder" of DSM-III) and psychotherapy alone can be tried first, medications later if the outcome is poor. However, the physician should be aware of the risk of neglecting psychiatric medications over a long period of time where symptoms of depression are severe, as that situation already has given rise to malpractice suits.

Schizophrenia in our time primarily is met in the community in young adults who quickly come in and out of psychiatric hospitals and/or stay for years at home, vocationally disabled and without adequate social skills. Unfortunately, maintenance medication does not foster social recovery. Participation in ordinary or traditional day treatment may also keep the patient at a particular level of performance without improving it, thus in a sense, also fostering chronicity. Specific training in social skills has been described as promoting better recovery more often. In Florida at present, there is an attempt in public psychiatry (such as in community mental health centers) to create residential units for chronic schizophrenic patients, such units being based primarily upon vocational training as the main factor in planning, treatment and progression through different levels.⁸

There often is a hiatus between the work done in the acute inpatient unit and the subsequent outpatient setup where the patient may be asked, for instance, to come once a month to see the psychiatrist for medication, with or without concomitant attendance at a day treatment program or similar activity. We are impressed with the acute needs of such patients during the first few weeks after discharge from the inpatient unit, and we believe better attention to such needs would prevent the higher rate of relapse after admission. Various authors have described the concept of "outpatient stabilization phase"¹ where for several weeks after discharge from the inpatient unit, patient and family meet with the assigned therapist or doctor to discuss current issues; unrealistic expectations are dispelled, and the recent psychotic episode is discussed, so a patient and family acquire a better understanding of the connection between stressful events and decompensation. Anticipatory planning can be done at this stage, along the lines of what we previously mentioned as the key question of "What would you do differently to avoid this breakdown in the future in the same situation?" It is claimed that with the combination of psychiatric chemotherapy and such family therapy, the relapse rate can be diminished.

Indication for psychiatric drugs is strengthened by: presence of psychosis or agitation; urgent need to improve necessary daily functioning by medication; an emotionally intense environment; opportunity to obtain good cooperation between the professionals; availability of a reliable person to oversee administration of drugs; evidence of familial incidence of mental illness; and history that the particular medication was helpful to the patient previously under similar circumstances.

Indication for psychiatric drugs is diminished by: availability of supportive network; availability of adequate psychotherapy; evidence that the patient has negative feelings about drugs; evidence that taking drugs diminishes the patient's efforts to learn to cope better; evidence of a serious risk of overdose; previous tendency to abuse various drugs or alcohol; evidence of bad effects with all previously tried drugs; evidence of poor physical condition which diminishes tolerance for the intended medication. When psychiatric drugs are used, involvement of the patient's family in counseling improves results, especially in schizophrenia.

In conclusion, it appears to us that this topic of combining psychotherapy and prescribing of psychiatric drugs should be receiving more attention because of its timeliness and because of the large numbers of people who are affected by this type of professional work. With so much critical public attention being focused singly upon psychotherapy and then again upon psychiatric medications, it will not be long before the subject of coordination between the different professionals will be spotlighted; it will help to have some of our own answers ready by that time.

REFERENCES

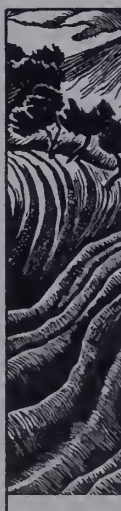
1. Beitman, B.D., Klerman, G.L., *Combining Psychotherapy and Drug Therapy in Clinical Practice*, Spectrum Publications, 1984.
2. Kaplan, H.I., Freeman, A.M., Sadock, B.J., *Comprehensive Textbook of Psychiatry/III*, Williams & Wilkins, 1980, p. 3352.
3. English, O.S., Finch, S.M., *Introduction to Psychiatry*, Norton, 1957.
4. Berstein, J.G., *Clinical Psychopharmacology*, John Wright, 1984, p. 5.
5. Jenike, M.A., *Geriatric Psychopharmacology*, PSG Publishing Co., 1985, p. 6.
6. "Economic-Related Issues Top Assembly's Agenda at May Meeting," *Psychiatric News*, June 5, 1987, p. 16.
7. Simons, A.D., Garfield, S.L., Murphy, G.E., "The Process of Change in Cognitive Therapy and Pharmacotherapy for Depression," *Arch. Gen. Psychiatry*, 41:45-51, January, 1984.
8. Operational Plan — Lee Community Support Project (ARTS), November, 1986 (unpublished manuscript).

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**Laser Technology
The New Wave in Medicine**

As the rock band bursts into a high energy hit, the concept has evolved to illuminate a major area of growth and progress in medicine.

Initially, these dazzling lights are also part of a new wave in medical technology and technology. Lasers, as a means which directs the light and energy by interaction of electromagnetic waves, are considered to be one of the most dramatic medical innovations of the 20th century.

After it became known that the "laser" of light is a concentrated beam of light, it was used in the field of medicine to treat various conditions.

Lasers have come a long way since they are now used in a multitude of medical procedures and the ability to perform surgery with precision and accuracy.

In the early to mid 1970s, ophthalmologists began using lasers to treat diseases of the eye, including the leading cause of blindness in the U.S., which is caused by diabetic retinopathy.

Since that time, lasers have proved to be invaluable in the field of ophthalmology. In fact, lasers have been hailed as the major contribution to the progression of ophthalmology in the U.S. during the past 10 years.

Lasers have been used to treat a wide variety of eye diseases, including cataracts, glaucoma, and macular degeneration. They are also used to perform eye surgery, such as LASIK, which is used to correct nearsightedness, farsightedness, and astigmatism.

For the many types of lasers used in ophthalmology, the laser light is used to cut or reshape the cornea, which is the front of the eye. The laser light is also used to treat the retina, which is the back of the eye.

Other advantages of the laser include shorter recovery time, reduced pain, and minimal scarring for the patient.

more preventable deaths would have been documented in the head-injured group since studies have shown that 25 percent or more are preventable.¹ The outcome following head injury is much more difficult to ascertain relative to preventable death and disability than deaths due to poorly treated hemorrhagic shock. Our study evaluates outcomes felt to be unequivocal, but I encourage analysis of head-injured patients by others in the future.

In response to Dr. Luzzi, no preventable deaths occurred in the single Level I institution. Preventable deaths do occur in Level I institutions but the preventable death rate is five to 15 times less than in non-verified hospitals.²

I am perplexed by Dr. Schlanger's comments. Since current destination guidelines demand that patients be taken to the closest hospital (not necessarily the closest Level I hospital), how has trauma care been improved in the seven or eight non-verified institutions which routinely receive severely injured trauma patients? There has been a gross overproliferation of trauma centers in Columbus. The American College of Surgeons recommends one trauma center per million population to minimize duplication of resources, maximize efficiency and avoid dilution of experience and decaying of skills. Verification of five hospitals as Level I trauma centers satisfies the hospital industry by maintaining the status quo but produces inferior care for the patient with serious injuries as this study testifies so clearly. A subsequent analysis of coroner's records beyond 1983-84 demonstrated a far greater number of preventable deaths — as many as 40 or more per year — in the Columbus metropolitan area. While it is easy for Dr. Schlanger to "suspect that the number of preventable deaths has decreased by 90 percent or more," the

continued on page 596

Evaluating Orthopedic Disability, A Commonsense Approach Second Edition

T. Rothrock Miller, MD, Medical Economics Books, Oradell, N.J.

We are always looking for the quick solution, the easy way out, the fast answer to even the most complex problem. We have always been so terribly busy, so burdened, so aware of the need for exactness and correctness and still so short of time that any shortcut has been a welcome beacon on the stormy sea of demands we founder in. In medical school, we were assigned our reading in Anderson's text on pathology, a large and authoritative tome. Yet the night before a test, with assignments in two other subjects as well, we often turned to "baby" Anderson for the quick answer; maybe not enough material for a truly erudite response to possible questions the next day, but enough straight fact that "bull" might suffice to finish the paragraph. In medicine, we had Cecil or Harrison to look to when faced with a challenging diagnostic or therapeutic enigma on the wards, but what did we carry in our pockets? The *Merk Manual*. And for orthopedics?

Very few of us had much interest and therefore very much exposure to orthopedics in those days. For orthopedics, many of us carried around the *Handbook of Orthopedic Surgery*. It was hardly a five-year post-graduate program compacted into 542 pages, but I dare say many have gone out into practice with no more than those 542 pages as their armamentarium of orthopedic knowledge.

Well, sir, there ain't no free lunch and there ain't no quick fix. And that surely pertains to the art and, maybe, science of evaluating orthopedic disability. Probably nothing impacts the American economy through health-care channels with a greater price tag than disability, unless maybe the effects of cigarettes, but I doubt it. The cost in lost time and medical benefits payments, the cost of legal defense and product or service liability and other disability-related costs are all passed on to the consuming public. The growing roles of disabled on Social Security further burdens an

“Evaluating Orthopedic Disability is a philosophical guidebook for the traveler on the treacherous road of disability evaluation rather than the ultimate reference book for the experienced evaluator.”

already teetering pillar upon which millions of retired depend. Add the high cost of settlement for disability in personal injury cases and add a lot of other things not coverable in a short report and the enormity of the burden that rests upon the shoulders of the physician called upon to determine “disability” can be seen to be appreciable.

A physician called upon to evaluate a fellow human being and report upon his/her disability, which really means “compensable disability,” assumes a great responsibility when agreeing to do so. He becomes a one-man judge and jury who is beholden to society to protect their interests and keep them from getting ripped off by a malingering turkey and he is beholden to the person he is examining to assure that person of every assistance and benefit due him as an injured party and a fellow member of a caring society. It is not an easy task nor one to be undertaken lightly. True, the physician’s report is only one factor in reaching the ultimate decision on the degree of disability but it is the professional statement on impairment of function that may stand for some time before being challenged or supplanted. It must be given with great care and sincere impartiality.

Dr. Miller’s book, *Evaluating Orthopedic Disability, A Commonsense Approach*, is, as its name suggests, a philosophical guidebook for the traveler on the

treacherous road of disability evaluation rather than the ultimate reference book for the experienced evaluator. It is a small book, a mere 104 pages, and many of them are devoted to illustrations of complex maneuvers such as turning the head to the right and then turning it to the left. It completes each chapter with a set of guidelines that cover, at best, 25 percent of the problems one might see in a series of 100 cases and, even then, assumes that a wealth of knowledge in orthopedics was assimilated in school along with industrial medicine (which was not taught in school). The regional chapters dealing with cervico-thoracic, upper extremity, low back and lower extremity areas are preceded by five pages of essentials and followed by 13 pages of examples. Just a bit concise for the task at hand.

Yet diminutive size, homey-chatty style and some wasted space on useless illustrations do NOT detract from the intrinsic value of the book which is, as noted, philosophical. The book will not stand alone in guiding the uninitiated through a complex evaluation but, as Dr. Miller points out, neither will the AMA Guide which is full of formulae. But I rather disagree with Dr. Miller in that I feel that formulae, percentages and charts, though no substitute for good judgment, can, if widely used and accepted, serve as a basis for computation and as a medium of communication

among others who use the same language. This book does, however, put evaluation into a proper perspective as the evaluation of *functional capacity* with the responsibility of occupational disability falling to members of the industrial commission or other determining body. It imparts a feel for the job that can only be imparted by someone like Dr. Miller who apparently has done this type of work for many years and has developed a sixth sense and a common sense by which he reduces the complex to some common denominators. He tries to pass this on to his reader and, in many respects, succeeds. I, personally, do not think that disability evaluation is quite so simple but I thoroughly agree with the exactitude he espouses in performing the evaluation.

Certainly this is an easy book to read in one sitting and is, therefore, a good book to read before undertaking the job of evaluating someone. It will not make a family practitioner into an orthopedist but it will help him understand the job at hand. It will not help the orthopedist with the tough cases but it will help him cope with the toughies by seeing them through the eyes of an older, wiser fellow who has had to throw away the charts a time or two and think things out on his own.

William L. Hassler, MD, is an orthopedic surgeon from Elyria.

how we have built our knowledge and moved ahead."

Yet, by combining and merging insights, new knowledge can be gained.

"The atomic bomb was built as a result of synergistic effort," he says. "A number of disciplines were involved."

And, if a weapon of such power could develop interprofessionally, think what might be achieved if the professions were to gather and

merge their insights for mankind's betterment — rather than its destruction.

"I hope, however, that those relationships will not be just biological or technological in nature," he says.

"Sometimes we're so busy teaching the technology that we miss the moral and philosophical teachings. We need to bring these social values back into the professions." **OSMA**

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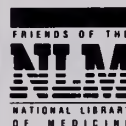
1. West J.G., et al. Systems of trauma care: a study of two counties. *Arch Surg* 114: 455-460, 1979.
2. West J.G., et al: Impact of regionalization — the Orange County experience. *Arch Surg* 118 (6) 740-744, 1983.

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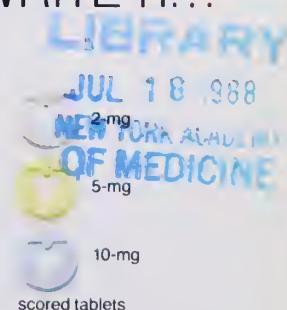
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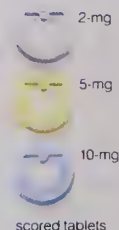


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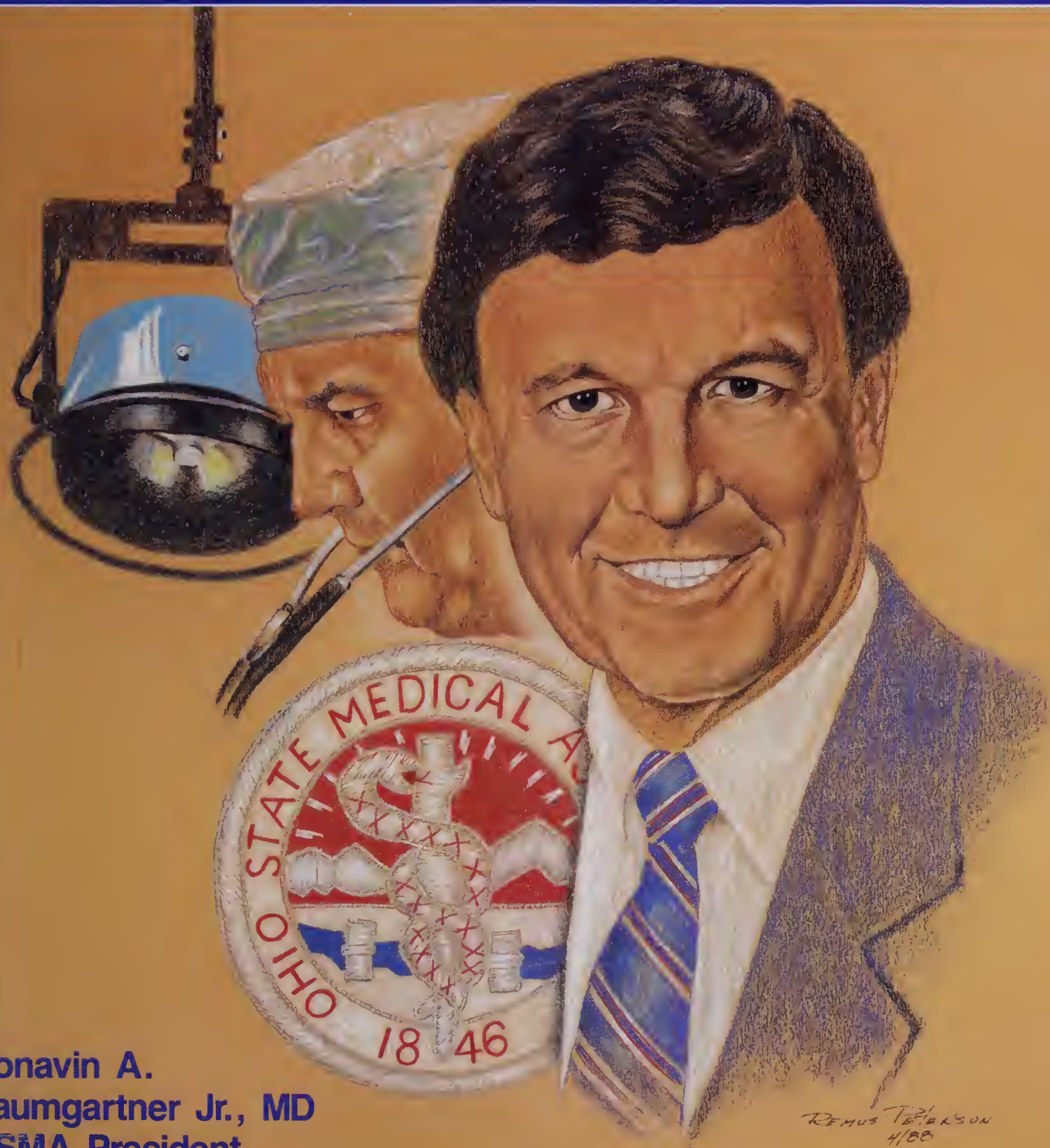
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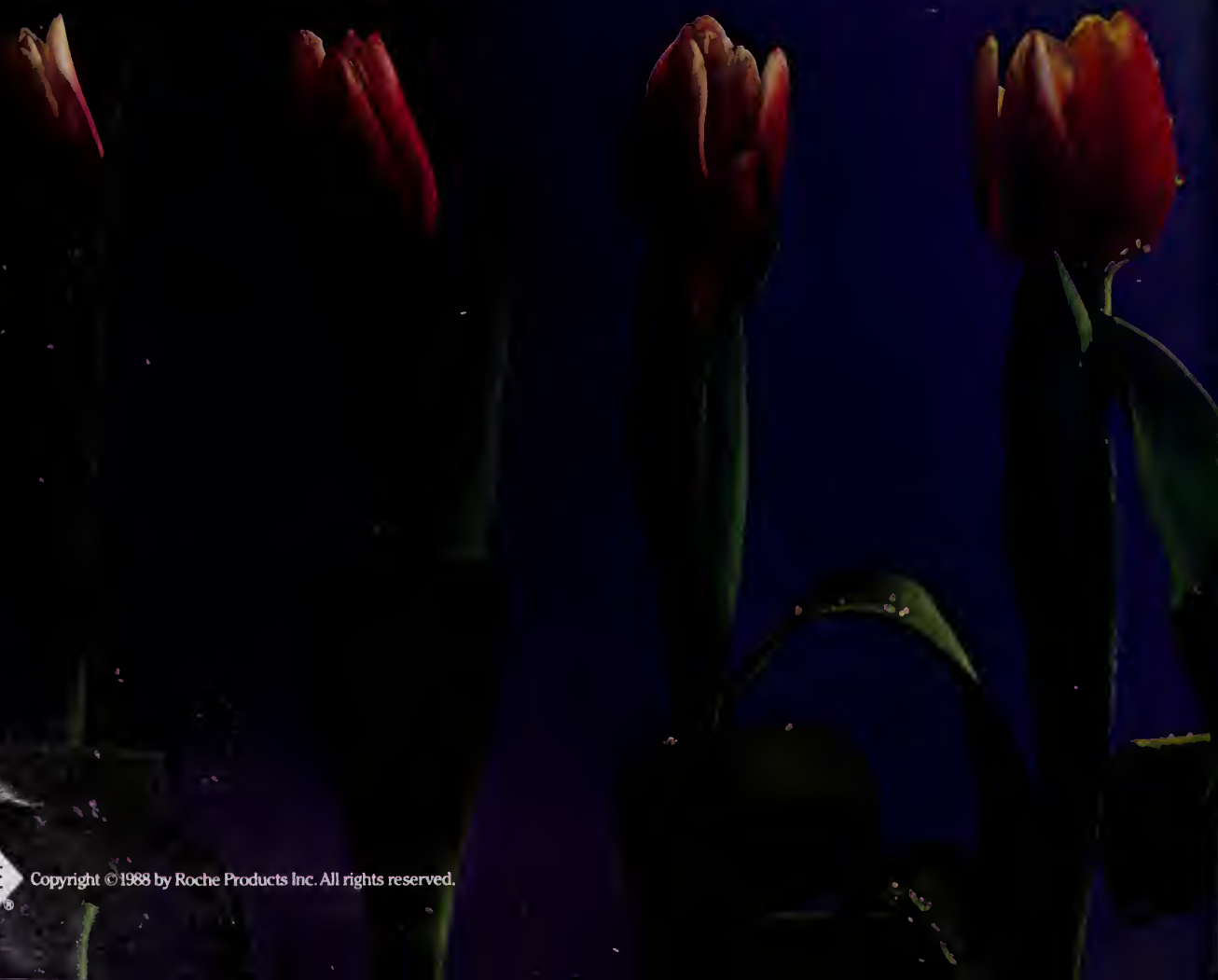
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AUGUST 1988



**Donavin A.
Baumgartner Jr., MD
OSMA President
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FROM THE EDITOR

Complete Coverage of "The" Meeting

Last month, *OHIO Medicine* gave you a glimpse of the highlights from this year's Annual Meeting. This month, we bring you complete coverage of the weekend-long event which took place this past May in Cincinnati.

The report of the first session, for example, will fill you in on the results of the Membership Outreach Program . . . how the Auxiliary fared this year . . . who was recognized for outstanding achievements . . . and what outgoing President D. Ross Irons, MD, had to say about his year in office.

Our "Ohio Medi-scene" section includes a story about the OMPAC Luncheon and its featured speaker, Paul Gillmor, President of the Ohio Senate . . . and don't miss the article based on the presentation attorney Richard Robinson gave before the hospital medical staff section. We think you'll find his comments regarding "A View from the Trenches: Medical Staffs Fighting Back" to be intriguing.

Our report of the final session features all the action, debates and dialogue which surrounded this year's resolutions. Look for the "Resolutions Key" which will tell you, at a glance, which resolutions passed . . . which were defeated . . . and which were referred to Council or committees.

Of course, the biggest news event occurring at any Annual Meeting is the installation of a new President. This year, Donavin A. Baumgartner, Jr., MD, was installed during traditional ceremonies before the House at its final session. We have profiled him on our cover — and inside, as well, in a special feature which focuses on his goals, dreams and ambitions for the year ahead. After reading it, we think you'll



agree that the OSMA, and medicine in general, couldn't ask for a stronger or more capable leader.

The September issue of *OHIO Medicine* will feature the subject of generic prescribing . . . the pros and the cons. If you have a strong view on this topic — either way — or wish to contribute something on this subject please let us know. Reader input is important to us — so let us hear from you!

Karim S. Edwards

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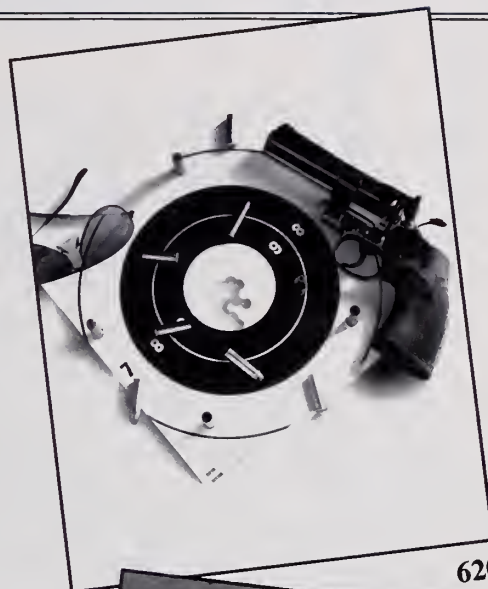
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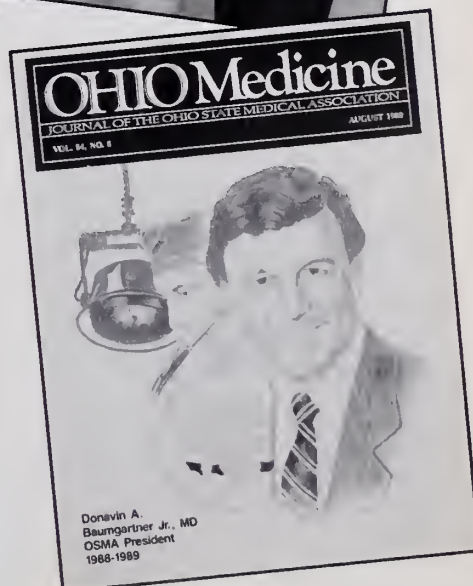
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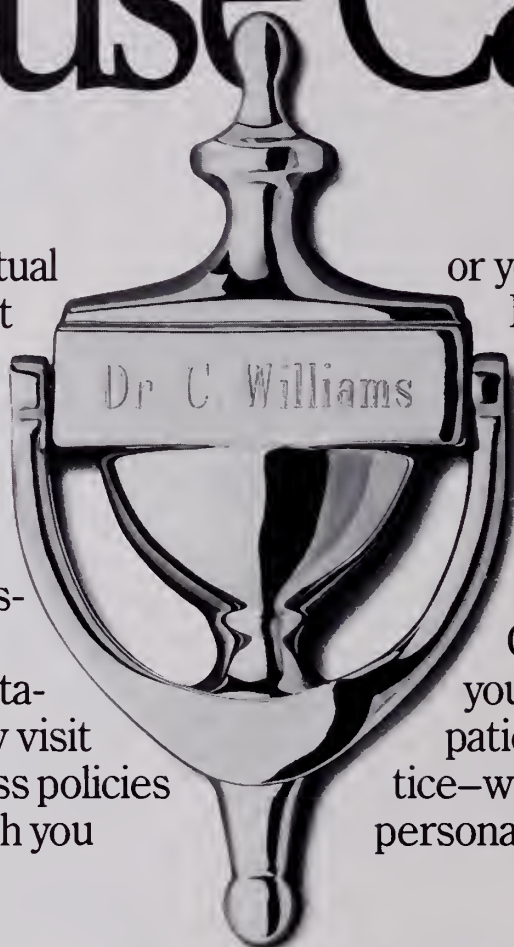


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UCR: A Different Definition

By Donavin A. Baumgartner, Jr., MD

My grandfather was a country doctor in Bluffton, Ohio who used to make house calls with a horse and buggy. Medicine was certainly simpler then. When summoned on a call, there was only one decision necessary. He had two horses, Maude, the old plodder, and Nellie, who was young and spirited. If the call was urgent and time made a difference, he would hitch up Nellie, otherwise he would use good old Maude. Times have certainly changed. Perhaps no single word better characterizes our times than the word "change." It pervades our entire life and often at a rate that can be frightening. Medicine is certainly not immune. New medical therapeutics, new schemes in health-care plans and changes in governmental regulations are an almost daily occurrence.

Now obviously some of these changes are good, some are not. Some we can alter and others we have absolutely no control over. Some may even be our own fault. As I see it, we have three broad alternatives in addressing these changes. The first is that of denial. The maybe-if-we-ignore-

Editor's note: *The remarks below are those of OSMA's new president, Donavin A. Baumgartner, Jr., MD made to the House following his installation this past May. They are printed here, in their entirety.*

them-they-will-go-away syndrome. Either denial or the related "stonewalling" seems to yearn for the good old days that are clearly gone forever. You have probably heard a colleague say something like "You won't see me having anything to do with governmental medicine." Unfortunately this ends up being merely rear guard action. Our second alternative is to merely float with whatever tide comes along and accept anything and everything with the attitude that we simply have no control whatsoever and must make the best of it. Individuals taking this approach of adapt and survive continue to mutter under their breath and often are the ones who criticize organized medicine for not protecting them from these outrages. Many of us have perhaps been guilty of this type of attitude when we blindly sign up with each

and every new health-care plan that comes along. This approach can clearly lead to trouble and, when applied to all medical change, is in essence one of accepting eventual defeat and loss of control of medical care. Our only realistic approach is to accept willingly those changes that are favorable and resist those that are not. Now I can hear you saying, "That's simple, but just how do we determine what is favorable and what is not?" When I spoke to a medical school graduating class some years ago I suggested that they need only one test to apply to anything new in medicine whether it be the cephalosporin of the week, the newest innovative operation or the latest health-care insurance scheme. I believe that this test is still valid today. All we need do is ask the question, "Is this in the interest of my patient?" Truly in the patient's interest and not just in the short term but the long run . . . If the answer is yes, then there need be no hesitation in accepting the new change, for in the long run, whatever is good for the patient will be good for the profession. If the answer is no,

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however, we have not only the right but the duty to speak up and resist.

For it is the physician who must always be the patient advocate. Families may wish to but are not equipped to do so. The government certainly has demonstrated that it cannot. Third-party payors clearly have different interests and politicians may claim to be, but even when very well intended, are subverted by the bureaucracy. We as physicians must reassert our role as the *only* true patient advocates.

There has been a steady attempt to erode the professionalism in medicine. Physicians and patients have been separated by the drive to reduce the practice of medicine to a business. Patients have become "consumers" and physicians and hospitals "providers." Health care is not provided and consumed — it is administered and received. There is a world of difference. We must not become vendors or boardroom executives. We must remain the patient advocate and the practice of medicine must remain a profession. The price will not be cheap. Eternal vigilance and commitment are essential. Our country now enjoys the best health-care system ever devised. There is no longer any doubt. In years past, such a statement would be challenged, but now students from all over the world flock to the U.S. for training. Those who used to offer the English system as ideal have long been silent. Even those who pointed to the Swedish system of health care as a model have been strangely quiet. To

protect and further improve this best of systems we must be dedicated. This will take time. This will take effort.

I offer to you three principles essential to such dedication. Since we are familiar with the now somewhat infamous term UCR, I have chosen these initials, but with a new definition having nothing to do with reimbursement and hopefully more meaningful to our profession. Unity, communication and responsibility should be our UCR.

Responsibility includes the commitment to the profession we have chosen — the return of what has been given to us by those in the past. This includes membership. We can no longer sit and wait for our colleagues to join us. We must recruit. A strong voice depends on numbers and we must assure that our numbers increase and remain strong. Specialty groups are necessary and vital, yet by necessity have limited interests. Only the federation of the county societies, OSMA and AMA is able, or even cares to speak for all physicians and their patients. We need look no further than Canada to determine the importance of membership . . . Before their present governmental health-care system, only some 40 percent of physicians were members of the Canadian Medical Association. Now that their association has been reduced to little more than a bargaining agent for fee schedules, the CMA has nearly 100 percent membership. Too little, too late. I therefore challenge you, each delegate and alternate of this house, to accept as part of the responsibilities of

the office, the recruitment of one new member each year you serve. This would not be a difficult task. Personal contact is best and you have a full 365 days to accomplish it. If we all accept this challenge, it could mean more than 400 additional new members by this time next year. Accomplish this each year and we could eliminate the need for future dues increases.

We need far more than membership recruitment and more than accepting the responsibilities of belonging. We need unity. The old play on words "We must all hang together or certainly we shall all hang separately" is even more true today. Those who would destroy the profession are playing a serious game of divide and conquer. We are being divided by specialty and set against each other. Hospital staffs are pitted against one another, the par and non-par physician division is exploited. The divisions abound, hospital-based vs. community, salaried vs. self employed and private practice vs. the HMO, IPA and now the new OWAs (other weird arrangements). We must not let this trend continue or we will defeat *ourselves*. Look to the lesson of England where their health insurance system was adopted only after the government promised the hospital-based specialists preferential treatment . . . a promise that proved temporary. We must return to the realization that we are first physicians and second we are dermatologists, family practitioners and orthopods. We must not lose sight of the fact that we have far more similarities than

differences and that unity is absolutely essential to maintaining the profession. No longer can we stand by because "that only hurts those ophthalmologists" or pass off new regulations because "that's the radiologist's worry." If we do not reunite as physicians, the battle is certainly lost and we will be to blame. Within organized medicine I am constantly amazed how often the particular specialty of a well-known and active physician is completely unknown to others . . . This is because that physician thinks and acts as a physician and views the interests of the profession. I challenge the physicians of Ohio to do likewise when pressures are exerted to divide. Look to the points of common interest. Think of the long term and recall the many lessons of the past.

Unity can largely be accomplished through the use of the third essential — communication. Let us dedicate ourselves to communication with our colleagues as a means of accomplishing membership and maintaining the unity of the profession. But let us go further and open communications with the government and third-party payors to at least attempt to avoid some of the disasters of the past. We must also address the most important aspect of communications, that with our patients. Communication with the patient can be the most potent weapon we have. When we take the time to point out what new changes are doing to *their* health care and set straight the propaganda to which they are

being subjected, we will create allies and, at the same time, clearly demonstrate our advocacy for the patient. We have allowed

propose a system to assist the individual physician in such communication by creating periodic issue cards containing a



"UCR . . . unity, communication, responsibility."

others to suggest to patients that we are not their advocates but their adversaries. We must take the time and effort to correct this misconception. Each year the polls show that patients feel that "Doctors don't take enough time with their patients, doctors don't talk to patients or care about them, etc." On the other hand they respond that "My doctor is different." This is highly significant. They know and trust their doctor. They need to hear the truth from their own doctor more than ever before. This year we will be continuing the fine work of the communications projects already under way but, in addition, will

short but pertinent message that can be communicated to the patient in written or, better yet, verbal form at, say, the end of an office visit. I submit that if each physician would do this regularly, we could assure ourselves of complete success. Being too busy will no longer suffice as an excuse if we are serious. No physician can remain an island and "just practice good medicine" as much as we might wish that were true. Taking the time to demonstrate you care is important. Show them you are their advocate and suggest what they can do about their problem with health care. There is

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little question that 10 letters of complaint received from voters has far more effect on a legislator than 100 from physicians. Even a referral specialist has this opportunity. Include the referring doctor in your statement. "Dr. Weber and I feel that . . .," "You can help Dr. Curtiss provide even better care to you and your family if you . . ."

As I start my year in office I am offering several challenges. To the House of Delegates, I offer the challenge to increase membership and promote the responsibilities of the profession. To all of the physicians of Ohio I offer the challenge of reuniting as physicians first and foremost, to rededicate themselves

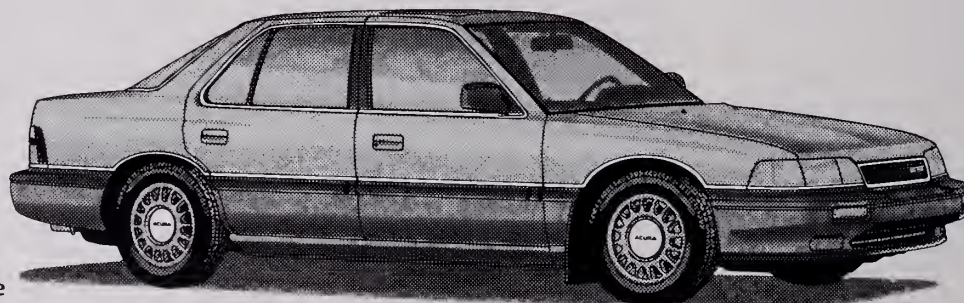
as the only true patient advocate and to increase communication not only with their colleagues but with the most important person in the system — the patient. To the government and third-party payors I offer the challenge of communication and cooperation. I shall ask them to do something new and different — talk to us *before* they create the monster. Accept us as partners rather than assuming us to be adversaries. I sincerely believe that if they try it they will like it as they find that we are more often than not actually on their side. After all, we have an interest in this health-care system that far exceeds theirs and we certainly will be able to keep them out of the trouble of their past pattern of unilateral action.

From what we have seen in the past, they have nothing to lose and we all have everything to gain. We offer them cooperation and communication.

United, our profession has great strength, but even with 100 percent membership, we are limited. By combining with our patients as allies we will have a force that can assure the protection of our health-care system and the professional approach. Join me this year in unity, communications and responsibility. We owe it to our patients. We owe it to those who have preceded us and to those who will follow, to protect and preserve this noblest of the professions. **OSMA**

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England's National Health Service: Still a Success

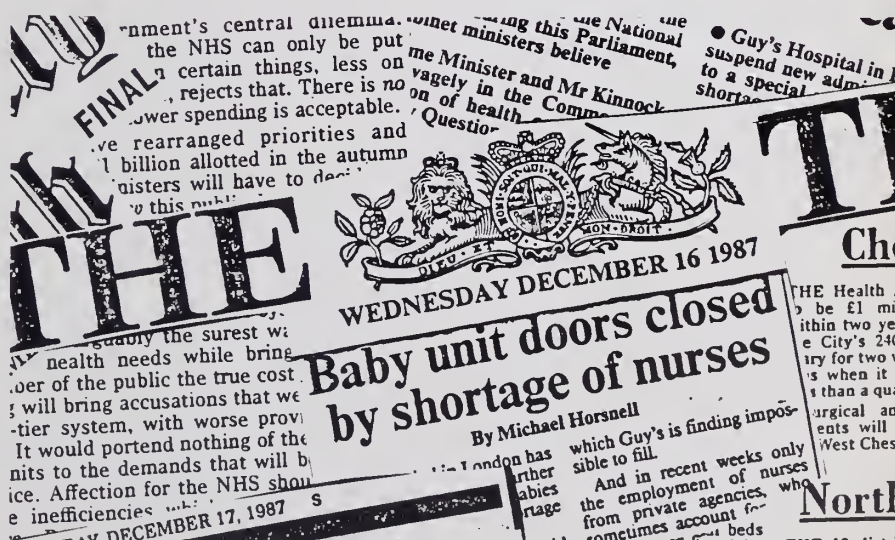
By Huw P. Williams, MD

Editor's note: The following article was sent in response to the news item, "England's National Health Service: Is It Ailing?" which ran in the May, 1988 issue of OHIO Medicine.

I enjoyed reading your recent article "England's National Health Service: Is it Ailing?", but feel the need to respond to put the record straight on a number of points.

The major problem seems to me that the article is based on news reports from the British press, which like journalists from all over the world, does not let the truth get in the way of a good story.

I will begin by addressing some of the more specific issues in the article concerning the reports of doctors and nurses leaving the NHS. All I can say is that if a junior doctor left his profession to become a merchant banker so that he could treble his income, then he has done his patients and his profession a great service. Nurses leaving the NHS has always been a problem and should not be seen purely as a result of poor pay. They have always been poorly paid, but last month they received on average a pay award of 14 percent (10 percent over the



inflation rate) which should help to keep some of them in their profession. However, there are other reasons why they leave, possibly related to their job structure and the restrictions that are put on them by their nursing administrators.

There is no doubt that there are problems with the health service at

the moment in the United Kingdom. This is not a new issue, indeed it seems to rear its head every five to 10 years. As long ago as 1970, a report was commissioned by the British Medical Association and this concluded that "it is highly improbable that any country in the
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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians



Rise in HMO-related complaints

The Ohio Department of Insurance reports that complaints regarding health maintenance organizations are running more than 50 percent higher this year than the three previous years combined.

Insurance officials are blaming the new complaints on the rapid increase in HMO growth. In Ohio, HMO memberships have been increasing in the state's 42 HMOs at a rate of 20 percent per year, and now stand at 1.3 million.

Most of the complaints are payment-related, and if they continue at the same pace, say officials, there are likely to be some 550 complaints this year. From 1985 to 1987, there were 360 HMO-related complaints.

Resident physician survey shows overall satisfaction

The American Medical Association's Center for Health Policy Research recently examined changes in postgraduate training programs and the effect on residents by utilizing data generated by 1983 and 1987 surveys of resident physicians. The center's findings are outlined below:

- The number of hours that residents are working has increased: 72 total work hours in 1983 versus 74.2 in 1987, with 56.6 patient care hours in 1983 versus 58.6 in 1987.

- After adjusting for inflation to 1981 dollars, residents are bearing more education debt: \$17,200 in 1983 compared with \$23,700 in 1987.

- The overall percentage of residents who moonlight has not changed dramatically but moonlighting still remains a substantial part of training programs, particularly for third-year residents: 53.3 percent of the third-year residents in the survey moonlight.

- More residents are training for five or more years. This suggests a trend toward greater subspecialization.

- After adjusting for inflation to 1981 dollars, program salaries have marginally increased: \$19,700 in 1983 compared with \$20,200 in 1987. The largest increase came for residents with more than five years of training: \$22,100 in 1983 vs. \$22,900 in 1987.

These findings suggest that residents have lost ground. They are taking on more debt and realizing only minimal salary increases while working longer hours. However, these shifts have had little impact on the overall satisfaction that residents have with their respective programs. Overall, most residents are satisfied with their programs and the economic-educational environments of teaching hospitals appear to be stable.

OD — Oh darn?

You write "OD" on your prescription blank. Now, what did you mean? Is the drug you prescribed to be taken:

- a. once daily
- b. as one dose
- c. omni die, "every day"
- d. on demand
- e. one drop at a time
- f. on departure

Don't laugh . . . "OD" can be

interpreted as any of the above — and sometimes with dire results, says R.A.P. Burt, author of a letter-to-the-editor which appeared in a recent issue of the *Journal of the American Medical Association*.

Burt cites the case of a colleague who prescribed a several-day supply of pills for a patient — to be filled "OD." The colleague meant (f.) on departure, but a nurse told the patient (b.) the pills were to be taken in one dose.

That, of course, led to an entirely different kind of "OD" . . .

Modern drugs are potent and the wrong dose or frequency of administration could result in disaster," Burt writes. "With ambiguous instructions, the risk is considerable, and we should not assume that colleagues will necessarily understand our abbreviation or even interpret it correctly."

New educational materials for you and your patient

The National Council on Patient Information and Education is making available brochures designed to educate the older patient about his/her medications, and what to ask their health-care providers about these medications. The materials are an outgrowth of the NCPIE's National "Talk About Prescriptions" Month, which was held last October . . .

The U.S. government's Office of Technology Assessment has recently released its second in a series of staff papers on AIDS-related issues. "AIDS and Health Insurance: An OTA Survey" presents the results of a questionnaire assessing the underwriting practices of commercial health insurers' Blue Cross/Blue Shield plans and health maintenance organizations for insurance applicants, and on the impact of AIDS on their claim costs. The survey report provides a view of AIDS testing in the context of other routine tests required by health insurers. It summarizes basic information on

underwriting practices and the use of medical screening by health insurers and documents how health underwriters are responding to the AIDS epidemic. The report also discusses the importance of attending physician statements, physical exams, blood and urine screening and health history questionnaires in the overall risk assessment for health insurers. "AIDS and Health Insurance: An OTA Survey," stock number 052-003-0193-3, is available for \$2.75. Send prepayment to Dept. 36-H Superintendent of Documents, Washington, DC 20402-9325; or to order with VISA or MasterCard, phone (202) 783-3238.

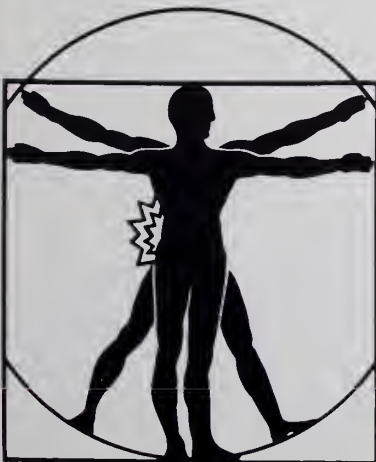
The OSMA Department of Communications offers a variety of patient education brochures explaining everything from Medicare to AIDS. For a complete list, or to order, write: The Department of Communications, Ohio State Medical Association, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824, or call 614-486-2401.

MEDICINE:



*Before you
take it,
talk about it.*

New surgery for back pain developed by Ohio physicians



Six Ohio surgeons have developed a new operation for patients with pinched nerves or degenerated spinal discs which reduces both convalescence and the need for repeat surgery.

The technique, posterior lumbar interbody fusion, was developed by doctors Guy Sava, H. Paul Lewis, P. Robert Schwetschenau, C.T. Lee, Melvin Whitfield and Frederic Helmer, who make up Neurological Surgery Associates in Hamilton, Ohio.

The operation removes the troublesome disc and replaces it with pieces of bone between the vertebral bodies — allowing the vertebrae to fuse and become

stronger and more stable, while maintaining adequate space for the nerve. Previously, the most common way to solve the problem was to remove the disc — but while removal alleviated any immediate problems, it rarely improved back pain and frequently the situation would reoccur.

Most of the people eligible for the operation, in fact, are patients who have had previous unsuccessful surgery.

The operation, developed about five years ago and recently presented to the American Association of Neurological Surgeons, is becoming increasingly popular nationwide.

IMAGINE A MACHINE THAT CAN DO THIS TO RENAL CALCULI

We're proud to announce the introduction of Extracorporeal Shock Wave Lithotripsy as a new feature of our kidney stone treatment program. This new device makes it possible to pulverize and eliminate kidney stones without invasive surgery. Now you have the opportunity to participate in this state-of-the-art procedure at CAMC's High Tech Center here in Charleston, West Virginia.

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As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

We're encouraging all area urologists to apply for privileges in Extracorporeal Shock Wave Lithotripsy. We invite you to visit CAMC and see the lithotripter in action. Come and learn about this revolutionary therapy. We will happily provide you with a brochure for your use as well as brochures for your patients.

For your brochures or other information about Lithotripsy and our kidney stone treatment program, call CAMC: in West Virginia at 1-800-654-0159; from out of state, call 304-340-7315.

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COLLEAGUES



Top to bottom: Henry G. Krueger, MD . . . Emerald Health Network VP; Daniel W. Van Heeckeren, MD . . . Cleveland Academy President; and Richard Nowak, MD . . . Distinguished Service recipient.



HENRY G. KRUEGER, MD, North Olmsted, has been named assistant vice president of medical affairs at Emerald Health Network . . . **DONNA L. STAHL, MD**, Cincinnati, has been named one of eight 1988 Career Women of Achievement by the Cincinnati YWCA . . . **RUSSELL MALCOLM, MD**, Middletown, has been recognized by the American Heart Association for more than 20 years of service to the organization . . . **ROBERT M. FUMICH, MD**, Cleveland, was one of only 30 physicians nationwide selected to provide medical services in June at the Olympic Training Center in Colorado Springs, Colo. . . . **ROBERT MCTRUSTY, MD**, Ashtabula, has been named medical director at Ashtabula County Health Center . . . **GARY L. GILLEN, MD**, Circleville, has been appointed to the Love Canal Medical Funds Appeal Board, a body that examines medical claims made by residents of Niagara Falls, N.Y. (Love Canal) for medical problems sustained from exposure to toxic chemicals that emanated from a former landfill . . . **MARY LOIS WHITACRE, MD**, Marietta, has been inducted into the Southeastern Ohio Women's Hall of Fame . . . **DANIEL W. VAN HEECKEREN, MD**, Cleveland, has been installed as president of the Academy of Medicine of Cleveland. Other officers include President-Elect **RONALD R. PRICE, MD**; Vice President **DONALD W. JUNGLES, MD**; and Secretary-Treasurer **O. DAVID SOLOMON, MD**, all of Cleveland . . . The Academy also honored five of its members with traditional awards: **DOUGLAS J. MOORE, MD**, Cleveland was honored post-humously as Clinician of the Year; Distinguished Service awards went to **RICHARD B. FRATIANNE,**

MD, and **RICHARD J. NOWAK, MD**, both of Cleveland; and **WILLIAM D. HOLDEN, MD**, and **WILLIAM S. KISER, MD**, both of Cleveland, were awarded Distinguished Membership . . . **STEVEN BORRON, MD**, Cincinnati, has received the 1988 Jean Hollister Award from the National Emergency Residents' Association in recognition of his life-saving efforts on behalf of a child who had been struck by a truck and critically injured . . . **GEORGE PARKER, MD**, Delaware, has been inducted into the Central Ohio Senior Citizens' Hall of Fame . . . **SHELDON SIMON, MD**, Columbus, has been named chairman of the Committee on Basic Sciences for the American Academy of Orthopedic Surgeons . . . **JACK H. RUBINSTEIN, MD**, **REGINALD C. TSANG, MD**, and **JOSEPH E. LEVINSON, MD**, all of Cincinnati, were recently honored for their contributions to the welfare of children at the "Clarion for Kids" benefit . . . **STEVEN L. RICHARDSON, MD**, Columbus, has been appointed assistant vice president of medical affairs at Peer Review Systems, Inc., a Columbus-based medical review firm . . . **THOMAS A. SALADIN, MD**, Cincinnati, has been elected to the board of directors of the American Academy of Medical Directors . . . **STEPHEN STROBEL, MD**, Cincinnati, has been elected president of the Cincinnati Society of Pathology for 1988-89 . . . **FREDERICK C. ROBBINS, MD**, Cleveland, has received the Camille Cosby World of Children Award . . . **W. THOMAS JACKSON, MD**, Toledo, has been named chairman and professor of the department of orthopedic surgery at the Medical College of Ohio.



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DONAVIN A. BAUMGARTNER, JR., M.D.
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45	695.00	610.00	1345.00	1165.00	1990.00	1682.50	2615.00	2215.00
55	1457.50	1377.50	2870.00	2675.00	4277.50	3985.00	5665.00	5295.00
FEMALE NONSMOKER RATES								
Age	\$250,000		\$500,000		\$750,000		\$1,000,000	
	Std.	Select	Std.	Select	Std.	Select	Std.	Select
35	\$ 290.00	\$ 235.00	\$ 535.00	\$ 425.00	\$ 775.00	\$ 610.00	\$ 995.00	\$ 795.00
45	595.00	452.50	1145.00	845.00	1690.00	1232.50	2215.00	1625.00
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* Applicants will be considered for select nonsmoker rates if 1) they have not smoked in the last ten years 2) family medical history is clean 3) weight has been within normal limits for the past two years and 4) medical history and current health is good. All nonsmokers not eligible for select nonsmoker rates will be considered for issue under standard nonsmoker rates. Smoker rates are also available.

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OHIO MEDI-SCENE

Financial help for caregivers . . . Medicaid tips . . . Elvis Presley lives! . . . Medicine and politics . . . high-tech, low-touch, high-cost medicine . . . OSMA publication wins an award . . .

Caregivers of at-home elderly: Is financial relief in sight?

Though the institutionalization of elderly persons is increasing, the majority of disabled elderly still live at home, cared for by their families. It is apparent that those caregivers often experience a good deal of physical and emotional stress. But the financial strain on the family caregiver is an important factor as well.

Recently, there has been a movement

in several states to alleviate some of the financial burden of those family caregivers for the elderly. David Biegel, a social work professor at Case Western Reserve University, has studied this phenomenon. On April 27, he presented his results in a paper entitled "Economic Supports for Family Caregivers of the Elderly."

The paper was part of a "Spectrum of Research on Aging and the Aged" conference, sponsored by CWRU's University Center on Aging and Health.

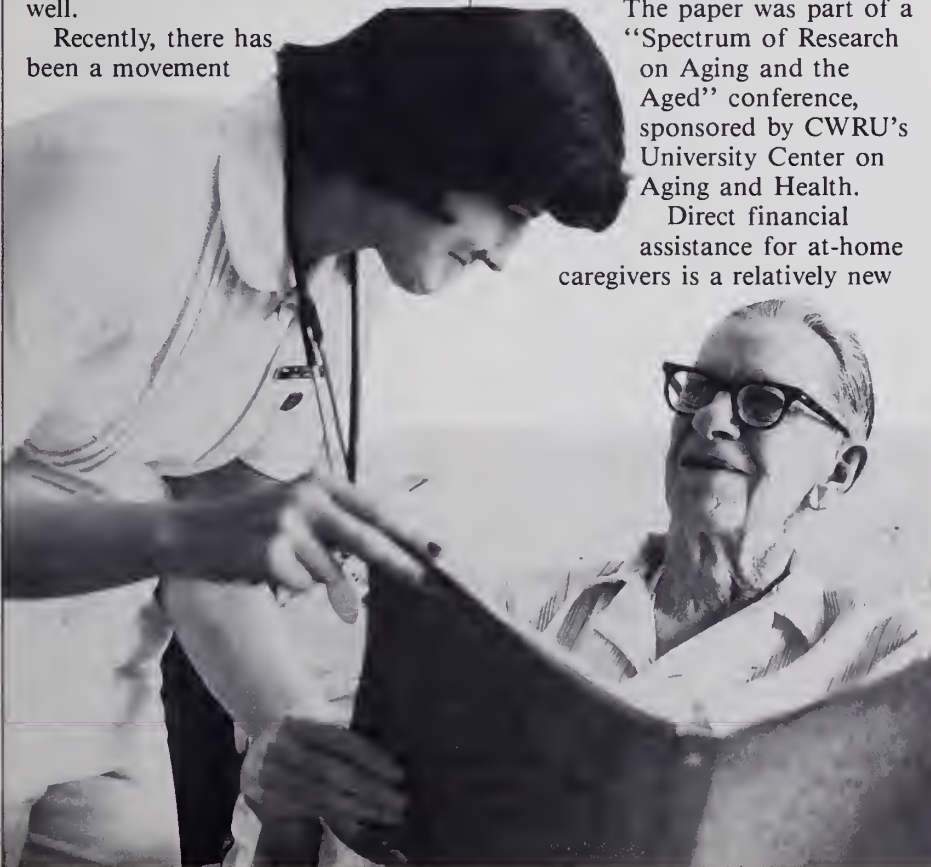
Direct financial assistance for at-home caregivers is a relatively new

phenomenon. "Until very recently, most supports for family caregivers of the elderly have been in terms of provision of services," Biegel notes. But since 1980, several states have implemented financial aid programs for the family caregiver.

Though Ohio has service programs such as Passport, directed at the at-home elderly, it offers no financial support for the family caregiver. At the time of the 1986 study, there were 23 states with such programs. But the rationales for their existence, as well as their implementation schemes and efficacy, seemed almost as numerous.

A common theme of all the states' programs was the realization that family caregivers provided a large amount of informal support at substantial savings to the state (when compared with the high cost of institutionalization). Many of the states hoped their programs would foster *continued* provision of care by the family at home. The financial aid was hoped to delay or prevent institutionalization of the elderly person. Biegel found that other states had a more ambitious goal, hoping to "encourage families who are not now providing care, to do so." But Biegel does not believe this is realistic. "Clearly the limited

continued on page 612



OHIO MEDI-SCENE

Caregivers of at-home elderly . . . *continued*

amount of economic support . . . would undoubtedly (fail to) encourage anybody who wasn't providing care to do so."

Implementation schemes were similarly varied among the states surveyed. Financial supports included tax credits, direct payments, or a combination of the two. When direct payments were given, the amounts differed considerably from state to state, ranging between \$119 and \$400 per month. And while some state agencies granted money directly to the elderly person, others denied payment to the disabled person or their spouse; they required that the payment go instead to another family member.

Though there was a wide variety of methodology between different state programs, Biegel had

communication between the various state agencies. "Often, state agencies on aging seemed to reinvent the wheel," Biegel said. He noted that although several of the states had financial support programs for families of mentally retarded persons, they failed to use those systems as models. Additionally, in some states with financial aid programs for the elderly, the aging agencies were actually unaware of their existence. "Unfortunately," Biegel adds, "sometimes administrative obstacles, such as lack of information, lack of coordination, or competition between state agencies, prevented the maximum integration of economic and service supports."

Varying eligibility criteria and limited funding were other stumbling blocks which hindered maximal utilization of the state programs. The most obvious shortcoming, however, was the lack of data on utilization of benefits and cost-effectiveness.

Though Ohio has no economic supports at present, Biegel later made some recommendations for the possible design of such a program. His advice to a state initiating a similar program would be "to set up something on a demonstration level, perhaps at a couple of different counties. (One could then) collect some data both in terms of who uses the programs and how well it meets their needs." It could be determined if, indeed,

this was the best use of the resources.

Biegel favors direct-payment programs to tax credits or deductions. "The (tax) credits,

"Clearly, there has to be a greater national involvement in terms of fiscal resources."

deductions or exemptions are relatively small amounts of money. Secondly, they're not able to be targeted to those that are most in need." A direct-payment program can be targeted at specific people, look at particular needs and tailor assistance to meet those needs. Another advantage is that direct-payment programs could be integrated with service supports for a more efficient delivery system.

The investigator also favors an enhanced role for the federal government. "Clearly, there has to be a greater national involvement in terms of fiscal resources," Biegel notes. "Part of the problem with a lot of the state initiatives is that . . . some states have a lot better programs than others." But he believes that one of the greatest needs at present is for more information. "It's an area that needs a lot more work before we go ahead (haphazardly) expanding programs in the future." — William J. Pomidor, MD

"Often, state agencies on aging seemed to re-invent the wheel."

difficulty determining which schemes were more effective. Information regarding the efficacy of the programs is quite scarce. Many states had no outcome data whatsoever; often there was no information on the number of people using the services.

Biegel was, however, able to observe some of the more obvious shortcomings of the programs. Most prominent was the lack of

Medicaid tips

The Ohio Department of Human Services makes changes in the drug formulary quarterly. Most of the additions and the deletions are based on recommendations presented by the Pharmacy and Therapeutics Committee. The Committee is comprised of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Waltenbaugh, RN; and Robert P. Reid, RPh, Chairman.

For your information the following changes will appear in the August 1, 1988 update.

Additions:

Adriamycin PFS, Allent, Amiloride/HCTZ, Ancef Inj., Anthraderm, Axid, Bactroban, Brethair REF, Calan 40mg, Carbinoxamine/Pseudoephedrine 8mg/120mg, Cefizox Inj., Chlorzoxazone 500mg, Claforan Inj., Clindamycin Inj., Cordran N, Cortisone 10mg, Danazol 200mg, Desipramine 75mg and 100mg, Docusate/Phenolphthalein, Doxepin 150mg, Entolase, Entolase HP, Erygel, Fluphenazines, Fml Forte, Haloperidol Inj., Hydralazine Inj., Isoptin 40mg, Kwelcof, Lactulose Syrup, Leucovorin 10mg, Lidex E, Mandol Inj., Maprotiline, Maxair, Metaproterenol Syrup, Metoclopramide Syrup and Inj., Morphine 2mg and 4mg Inj., MS Contin 60mg, Naldelate Ped Drops, Neo-Cortef, Neo-Cort-Dome, Neo-Decadron Topical, Neo-Delta-Cortef Topical, Neo-Medrol, Neo-Synalar, Nitroglycerin Patch 10 mg and 15mg, Norethin, Occlusal, Occlusal HP, Ocular Lubricant, Peridex, Perphenazines, Polycarbophil 625mg, Poli-Vi-Flor 0.25mg, Prenatal 1+1, Prinivil, Proctocream HC, Prolixin Conc, Proventil 0.083%, Thiothixene 20mg and Oral Conc, Unasyn Inj., Zestril, and Zymase.

Deletions due to discontinuation:

Accelerase, Liquamar, Mysteclin F, Neo-Delta-Cortef Ophth Soln, Pagitane, Pyopen, Seffin Inj., Theophyl SR 250, and Vi-Penta-F. Deletions to comply with federal regulations:

Dyazide, Haldol 10mg and 20mg, Hytone Cream 1%, Inderide 80/25, Loniten 10mg, Maxzide, Mellaril Conc 30mg/ml and 100 mg/ml, Nilstat Vag Tab, Mycostatin Vag Tab, Inderal 90mg, Procan SR 250mg and 500mg and 750mg, Pronestyl SR 500mg.

The maximum allowable prescribing quantity has been raised on all chronic maintenance

medications. Once the patient is stabilized, physicians will be able to write for quantities up to a 90-day supply in most cases.

Janet Bixel, MD, your OSMA representative on the P&T Committee, will keep you informed of changes in the Ohio Medicaid Drug Formulary. — *Robert P. Reid, RPh; Janet Bixel, MD*



OHIO Medicine Exclusive! Elvis Presley Lives!

Amid rumors of Elvis Presley sightings and mysterious voice-tapes — all presumably made years after Presley's death, *OHIO Medicine* now presents its own hard evidence that "the King" lives.

On the other hand — the photograph above may be a picture of Theodore Castele, MD, a

Cleveland radiologist and chairman of the Ohio delegation to the AMA. Dr. Castele recently appeared in a performance benefiting the Lutheran Medical Center of Cleveland. (Makes you wonder what the rest of the delegation to the AMA will look like, come the next Chicago meeting, doesn't it?)

OHIO MEDI-SCENE

The vital link between medicine and politics

“We’ve had a great year,” Ohio Medical Political Action Committee (OMPAC) Chairman Jerry Kimmelman, MD, told approximately 250 physicians and physician spouses in attendance at the 1988 OMPAC Luncheon, which was held at the OSMA Annual Meeting in Cincinnati. “In almost every county medical society and urban hospital, people have stepped forward to get involved.”

Physicians have begun to realize what a crucial role politics plays in forming the future of medicine and patient care, he explained. The steadily increasing membership in OMPAC attests to the fact that more physicians were willing to make a commitment on behalf of their profession. “This year, membership has surpassed membership of all previous years,” he said.

But medicine will only realize its full potential when there is 100 percent physician participation in OMPAC, Dr. Kimmelman emphasized. Every physician who is concerned about the impact of governmental action on organized medicine should be involved in OMPAC, he stressed. “OMPAC’s mission is to work hand-in-hand with OSMA policymakers to assure the voice of organized medicine is heard on issues of greatest concern to physicians and their patients,” Kimmelman added.

After expressing thanks to the OSMA and the hundreds of physicians and spouses who have

become involved in OMPAC’s cause, Dr. Kimmelman predicted that “OMPAC will rise to the political challenge before us.”

In recognition of the effort put forth by physicians and physician spouses, OMPAC honored a physician and a physician spouse for outstanding efforts to enhance political involvement and education within the Ohio medical community. The first annual **OMPAC Distinguished Service Award** was presented to A. Burton Payne, MD, of Ironton, Ohio. After accepting his award, Dr. Payne, an OSMA past-president, said, “When you get a plaque for something you like to do anyway, there’s not much to say about it.”

Receiving the first annual **OMPAC Physician Spouse Distinguished Service Award** was Rose Vesper of New Richmond, Ohio. Mrs. Vesper has been active as an OSMA Auxiliary representative on both the OMPAC Board of Directors and the OSMA Committee on State Legislation, as well as on numerous political and

community action committees. In her acceptance, she explained that her introduction to politics grew out of her initial interest and concern about government actions affecting the practice of medicine. Reflecting on her involvement, she stated she realized that physician

“If you’re not participating, you have to ask . . . who is?”

community involvement does play a vital role on the political front and can make a difference.

The highlight of the luncheon



was the keynote address presented by the President of the Ohio Senate, state Senator Paul E. Gillmor of Port Clinton, Ohio. Senator Gillmor's theme highlighted the need for medicine and politics to work together. In fact, he stressed, of the more than 1,300 legislative proposals currently being considered by the Ohio General Assembly, 10 percent impact some aspect of quality patient care, including such issues as medical professional liability, allied practitioner's scope of practice, third-party reimbursement, certificate of need, health insurance, and many others.

It's impossible for a legislator to be an expert in all of these health-care issues, Senator Gillmor explained. That is where OMPAC and OSMA, as well as individual physician, input become invaluable. "Your help is vital to us in the legislative process," he continued. "Legislators need to get accurate information from those who have the facts in order to deal appropriately with complex health issues."

Senator Gillmor pointed out that it is imperative that a profession such as the medicinal profession have a strong and active political organization as a means of self-preservation for both the individual physician and the practice of quality medicine. "OMPAC greatly assists your profession by enabling you to participate more effectively in the political process," he said. "If you're not participating, you have to ask, who is? Are my views being expressed? The only sure way to know is to be personally involved."

Senator Gillmor pointed to medicine's recent success in the battle for medical liability tort reform as a prime example of how a unified front can make a difference. It was a long hard fight, he stated, but "Substantial gains were made, and the OSMA, supported by OMPAC, was in the forefront of the successful campaign to pass meaningful



Above: OMPAC Chairman Jerry Kimmelman, MD (center) presents plaques to Rose Vesper (left) and A. Burton Payne, MD (right).



Left: Paul E. Gillmor addresses OMPAC members.

reform legislation."

Senator Gillmor said he also shares medicine's concerns about the impact of House Bill 150, Mandated Medicare Assignment legislation. "As long as I'm (Senate) president, we're going to oppose passage of the bill," he assured. This commitment was met with a round of applause.

Senator Gillmor has long been a "good friend" of organized medicine during his years of

service as a member and leader in the state Senate. He is currently a congressional candidate in the fifth congressional district which encompasses a significant part of northwest Ohio. After the November election, Senator Gillmor stressed, he hopes to maintain the "good friend" distinction as a member of Congress, as he works "for a better Ohio and a better America." — *Deborah Athy*

OHIO MEDI-SCENE



High-tech, low-touch, high-cost medicine

Beyond belief: the technological achievements of the 20th century.

But according to Leah Curtin, RN, editor of *Nursing Management* in Cincinnati, society's command of the ethical issues in the computer age hasn't kept pace with its high-tech progress.

In a report entitled "An Aging America: Ethical Implications for the Family and Society," presented at a technology and aging conference in Columbus, Curtin categorizes modern-day society as the third stage of the Industrial Revolution, in which there has been a multitude of unprecedented technological advances.

It is a time of robotics, lasers, computers, VCRs and disc players. It is a time so packed with transformation and changes that the American family is being overwhelmed, she says.

One result of high-tech advances in the medical field is that people are living longer, she continues. Children and grandchildren, "the young old," are being called upon more often to care for their parents as well as their children — thus the description, the *Sandwich Generation*. Families are finding that this caregiving can put a burden on their resources and their own health.

An increasing number of elderly are dying of chronic debilitating illnesses that require high-cost medical services. Thus the concern: Who will provide these services

and who will pay for the care?

As Curtin points out, "One catastrophic illness for many is all that stands between them and homelessness."

According to the conference's opening speaker, Michael Covert, former executive director of Health Services at University Hospitals in Columbus, the country is spending \$1 billion per day on health care. Unfortunately, he says, "We're not meeting the needs of all the people."

He reports that Medicare accounts for 40 to 50 percent of medical patients in the country. The average Medicare patient is a woman, age 85 or older, poor and single, he adds.

When one considers, Curtin points out, that two-thirds of the Medicare dollar is spent in the last week of the patient's life in the intensive care unit, ethical and financial questions are bound to arise. Are we bankrupting our system by pouring money into terminal patients? If we don't, then is there an assumption that it is more worthwhile to treat younger patients? Is there a consensus — will there ever be? — about keeping patients alive on

embrace technology, which has provided a cornucopia of miracles to medicine and other fields. But Curtin cautions that sometimes "The machines embody a dream of hope and health that is not kept."

She describes a modern-day hospital death as a sterile and impersonal event: The patient is hooked to machines, surrounded by monitors, transducers, a ventilator, the ever-present TV, an X-ray technician and respiratory technician, while 15 residents zip in and out of the room — all against a white, hygienic background.

"Where is the patient's humanity in all of this, if the

professionals are unable to add that most leavening element: human-to-human touch?" she asks.

Indeed, Curtin concludes, it is difficult to find answers in such complex and changeable times. "But this time of turmoil should not lead to simplistic solutions," she says. Solutions cannot be pulled magically from a hat — or reduced to a three-letter solution such as a DRG.

"We need to select from responsible alternatives the ethical means we need to accomplish our ends and determine the direction in which our health-care dollar is spent." — *Deborah Athy*

OSMA publication wins award

Medical/Staff BULLETIN

July, 1988
Vol. 2, Issue 7

"Machines embody a dream of hope and health that isn't kept."

high-tech, high-cost machines?

As medical craftsmanship continues to advance, the costs will continue to advance as well, Curtin says. And despite the sophistication of high-tech medical procedures, something is being forfeited along the way.

Computer technology does not always allow time for the human touch. And according to Curtin, "The more technological the intervention, the greater the need for human contact."

The American way has been to



Health Care Quality Improvement Act impacts physicians

Reviewing Physicians may receive antitrust immunity

Ed's note: This is the second part of an article outlining physician antitrust immunity, specifically under the Health Care Quality Improvement Act of 1988. The OSMA is currently drafting model policies for hospital medical staffs that will conform to the maximum due process standards. For more information, contact the Publications of Legal Services at (312) 770-0000.

Medical Staff Bulletin, the OSMA's monthly newsletter for hospital medical staffs, has won a Bronze Quill Award of Excellence from the International Association of Business Communicators.

The 17" X 22" poster-style newsletter is produced on a Macintosh Plus desktop publishing

Nursing shortage discussed at AMA-HMSS meeting

Representatives from Ohio hospital medical staffs met with physicians from other states at the American Medical Association's Hospital Medical Staff Section Assembly in Chicago June 22-26.

Among the topics discussed was the creation of a new class of bedside hospital worker — Registered Care Technologists — to help offset the current nursing shortage.

The RCTs would be trained to take a patient's vital signs and perform other tasks, leaving registered nurses free to concentrate on more skilled and vital patient management tasks.

The OSMA House of Delegates adopted a policy against introducing this new type of health care worker in hospitals, and has sent a resolution against creating RCTs to the AMA House of Delegates.

Also discussed:

- The implications and ramifications of the U.S. Supreme Court's decision in *Patrik vs. Bland*.
- Working with insurance carriers to resolve physician concerns with medical necessity, concurrent care and recertification guidelines.

ODHS offers AZT, home care programs for AIDS patients

Officers elected for HMSS

Officers for 1988-89 were elected at the Hospital Medical Staff Section's annual meeting in May.

Officers are:

- Chairman: Edmund W. Jones, MD
- Vice Chairman: Walter A. Reeling, Jr., MD
- Secretary: Frederick T. Suppes, MD
- Delegate: Charles B. Travis, MD
- Alternate Delegate: Keith B. Kaufman, MD

Medical Staff Bulletin wins Award

Medical Staff Bulletin has won a Bronze Quill Award of Excellence from the International Association of Business Communicators.

system. The first-place award was in the category of best desktop layout and design for an ongoing newsletter. Entries are judged on effective use of design elements, technical quality, organization of material and ability to meet stated objectives.

A NEW H₂ Antagonist

AXID[®] 300mg

nizatidine

Effective once-nightly
duodenal ulcer therapy available in a
Unique Convenience Pak
for better patient compliance



AXID[®]

nizatidine capsules

Brief Summary: Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests:—False positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions:—No interactions have been observed between Axid and theophylline, chlorazepate, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility:—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 550 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C:—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers:—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use:—Safety and effectiveness in children have not been established. Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to

determine whether these were caused by nizatidine.

Hepatic:—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular:—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine:—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic:—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental:—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other:—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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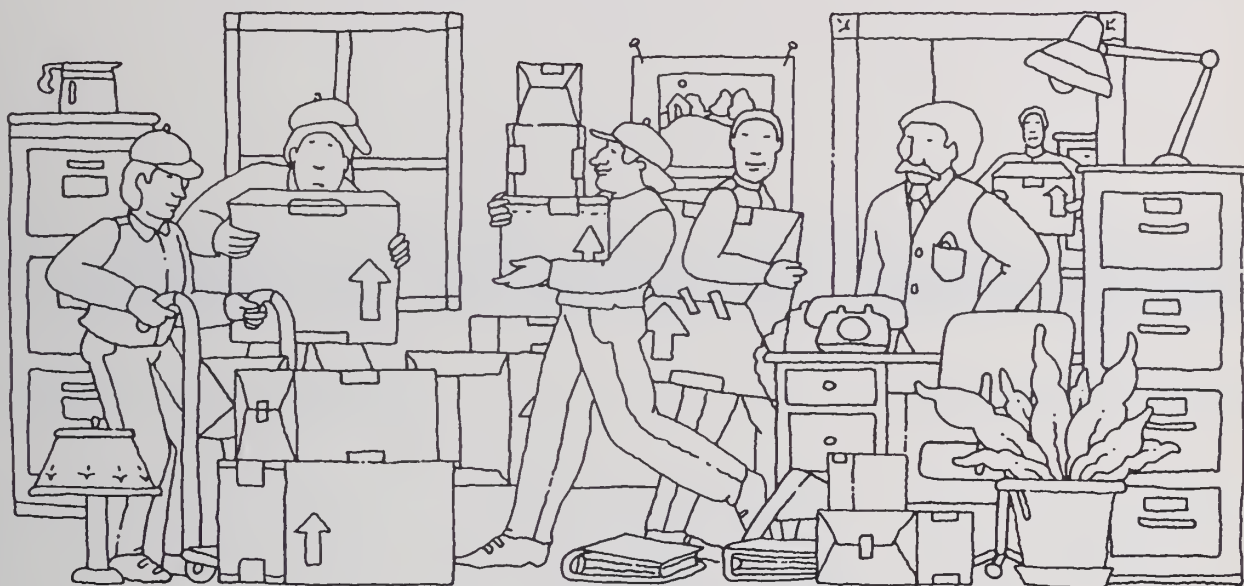


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On the Move . . .

The Ohio State Medical Association has changed its address from 600 S. High Street to 1500 Lake Shore Drive, Columbus, Ohio 43204-3824. The new telephone number is 614-486-2401.

Watch the OSMAgram or phone the OSMA Physician's Hotline, 1-800-346-OSMA for other announcements about the move.

Frustrated and confused by the changes flying around them, medical staffs are beginning to fight back — and some are actually winning . . .

Hospital Medical Staffs —

By Karen S. Edwards

You're on a hospital medical staff.

Suddenly, one day, the chief of staff calls you and says that the hospital is looking into the possibility of entering a joint venture with a group practice down the street. (At this point, some of you may be already experiencing *deja-vu*.) The chief, who is quite likely a politically savvy individual, has already heard the administrator/board of director's side of the story and now wants to meet with you and the other members of the medical staff to see if it's possible to come up with a proposal of your own — one that would effectively counter, or at least temper to some degree, the proposed joint venture.

Now — what do you think is likely to happen?

According to Richard Robinson, JD, former director of the California Medical Association's Division of Physician Contracting and Medical Staff Affairs and presently a principle in a California-based health-care consulting firm, there is a sort of composite response from medical staffs when faced with a joint venture proposal.

It is one of six typical scenarios of medical staff action Robinson described to the OSMA's Hospital Medical Staff Section during its annual meeting, held in

conjunction with the OSMA's Annual Meeting this past May. According to Robinson, the composite scenario goes like this: The chief of staff comes to the meeting and explains the joint venture as he or she heard it described by the administrator. The medical staff responds with a mixture of disagreement, confusion and chaos and is usually unable to reach a general consensus on the issue — let alone draft a proposal. Meanwhile, the administrator is getting pressure from the board, and eventually moves to accept the joint venture — without any input from the medical staff.

The other scenarios Robinson describes depict, as this one did, an often frustrated and confused medical staff — angry and dismayed by the changes flying around them. Yet many are beginning to fight back — and some are actually winning.

The "Fresno situation"

For example, there is the "Fresno situation," the second scenario described by Robinson, and one that is based on an actual incident. In Fresno, California, 96 physicians, many of whom were disgruntled members of medical staffs, asked themselves, why practice in a hospital? Why tie themselves down, they said, to the rules and regulations imposed by a

nonphysician board with little sympathy for any but the fiscal side of things? After all, these physicians reasoned, studies show that 70 percent of those admitted to the hospital stay less than three days. With full intention then of stealing at least 50 percent of the surgery business from all hospitals in the area, a freestanding surgery center was built by the group, who, shortly afterwards, also added an extended care facility. Both were passed under certificate-of-need requirements as pilot projects, Robinson adds. The facilities' success? Over 150 physicians are now involved in these centers if that gives you any indication.

Unfortunately, however, not all medical staffs are that lucky.

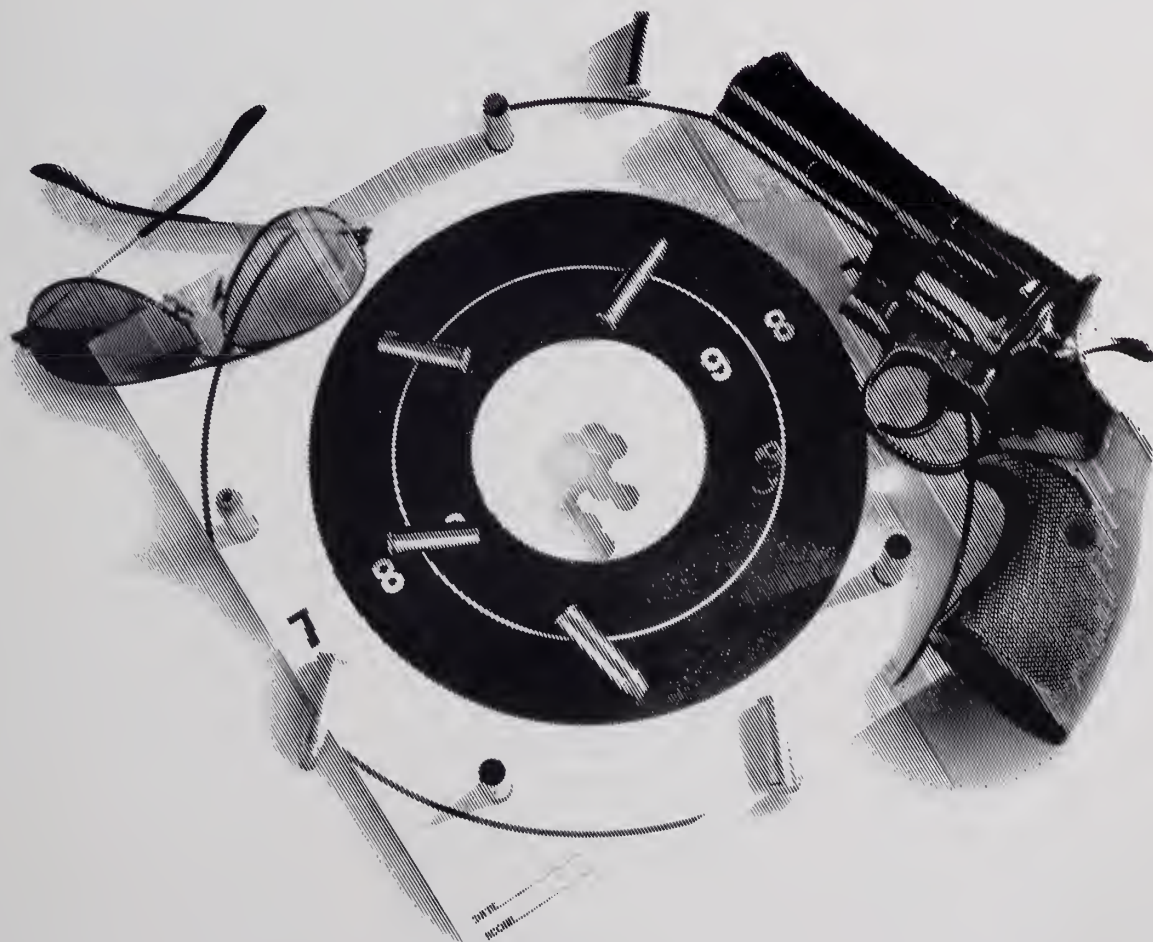
At the Eisenhower Center

Scenario number three describes a situation that occurred at the Eisenhower Medical Center in Palm Springs.

"The board of directors at this facility reads like a who's who," Robinson comments. He describes its members as wives of celebrities and politicians, wealthy socialites and other glitterati.

Troubles for the medical staff began when the board decided to involve itself in a medical staff election. The staff had selected a chief whom the board, for some

Fighting Back from the Trenches



“The Eisenhower Medical Center scenario is a classic example of how bad by-laws can hurt you.”

reason, did not approve. A letter was written to the medical staff announcing the board's disapproval, and requesting that another candidate be chosen. The medical staff, of course, was incensed, and decided to seek legal action.

“The only legal way that the action by the board could have been taken,” explains Robinson, “is if the by-laws had provided for it.”

And, to the medical staff's horror, they did.

“It's a classic example of how bad by-laws can hurt you,” says Robinson.

Amending by-laws in Lodi

But by-laws can also prove to be helpful, as was the situation at Lodi, California — scenario number four. Here, again, there was disagreement between the staff and the governing body about who should serve as officials of the medical staff. At Lodi, however, the administration simply announced that the governing body would amend the by-laws to extend the term of the present officers one more year. The medical staff had already held its election, however, and made that statement to the governing body, which in turn responded that they would not recognize the new officers — only those who had previously held the position.

The medical staff, however, knew and understood the hospital's by-laws. Believing such

an amendment to be illegal, the staff threatened the hospital with a lawsuit, and the hospital board, faced with possible legal action, rescinded its amendment.

A similar situation occurred in Los Angeles, Robinson continues. There, a chief of staff was hired by the hospital as its medical director. Typically in this situation, the medical director would forfeit the chief of staff title as he or she becomes a paid employee of the hospital. This particular hospital, however, was reluctant to lose its valuable ally in the medical ranks, so it sent a notice to the new chief of staff stating that it was changing the hospital by-laws to make the medical director a voting member of the medical staff.

Again, the medical staff gathered its ranks and fought back — successfully.

Not all battles being waged by the medical staff are against hospital governing bodies, however, there is some in-fighting as well.

Liposuction star-wars

In scenario six, which Robinson calls the liposuction dermatological/surgical star wars, a chief of dermatology complained to the chief of staff that the surgeons were not allowing the dermatologists to use the operating room.

“Once the surgeons were convinced that the dermatologists only needed the operating room for a couple of procedures, the surgeons agreed to be more

cooperative with the OR schedule,” says Robinson.

It also neatly sidestepped any questions of antitrust that might legitimately have been raised, he adds.

Still, as medical staffs begin to become more vocal with the hospital and with themselves — and begin assuming a higher profile — one fact remains clear.

“Very few doctors have experience in economic or managerial matters,” says Robinson, “and very few are trained to be leaders.”

He is quick to discount the crash course in medical leadership given at Estes Park, for example.

“That's a brainwashing institute — a boot camp for the hospital industry,” he declares. “Hospitals send you there so they can get the medical staff thinking the way they want them to think.”

As Robinson points out, there is no medical staff equivalent to Estes Park — nowhere hospital administrators or directors can be sent to be presented with a physician's perspective. At least not yet.

“We're working on it, though,” he says.

In the meantime, physician leaders are left to juggle an assortment of roles while trying to keep everybody happy. Even Henry Kissinger would likely find the task a challenge.

“A medical staff leader faces four responsibilities,” continues Robinson.



Richard Robinson, JD, relates stories of medical staff battles to those attending the OSMA-HMSS meeting in May.

“Medical staffs often view themselves as weak . . . But they are underestimating their power and influence in the marketplace.”

The first one is clinical — “a given,” says Robinson, “and the one most physicians are comfortable with.” Yet few medical staff leaders are in a position where they have any time left for clinical duties. Most, in fact, claim their practices suffer woefully while they are in charge.

Their managerial responsibility, on the other hand, consumes a large portion of their time, as does their business responsibility. The former includes organization, marketing, long-range planning, creativity (finding new ways to do things), contracts and drawing up position descriptions.

The latter is different from managerial responsibilities, says Robinson, and is involved with partnerships, alliances, risks and

positioning for the future.

The medical staff leader must be something, too, of an economic statesman — concerned with both medical staff money and hospital money.

“If the medical staff has to rely on other bodies for money, however, they will be dependent on that body,” says Robinson.

“That’s why financial independence of the medical staff is important. Otherwise, they are always hat-in-hand, trying to get money.”

Reaching a consensus

Robinson admits that it’s not always easy for a medical staff leader to get an economic consensus from the group. Medical staffs, he points out, often divide

and conquer, sorting themselves into different conclaves which appear, at times, to be diametrically opposed.

“They need to get together and reach a consensus in the midst of today’s competing economic interests, or there will be chaos,” he predicts.

Chaos may yet result, however, with the quality assurance/peer review issue.

“Dennis O’Leary is getting too far out front,” Robinson claims. “It’s important to rein him in.”

Robinson believes O’Leary — “who forgets what it’s like to practice medicine” — is making the JCAH a household word. “Be careful that he doesn’t push the principle that decisions should be based on computers and

How can physicians display their strength? "Get a bargaining chip," suggests Robinson.

numbers," he warns. "His goal is to look at a computer tape to determine the necessity of a survey."

There are resources available to medical staff leaders, however, that *can* help make sense from the chaos.

Robinson's first suggestion is to find a physician-friendly, or, if possible, a medical staff-friendly attorney. It won't be easy, though, he cautions.

"Of 90,000 licensed attorneys in California, 250 to 300 are familiar with health-care law, and of those, about 50 don't work for a hospital."

ID physician-friendly JDS

That's where the medical society — either county or state — comes into the picture.

"The societies can identify physician-friendly attorneys for you," he says, and they often develop a network of such attorneys so that, if a problem does occur, an attorney with some experience in the field can be called in.

Other resources include the medical staff "outcasts" — those physicians who are better known for their business than clinical acumen. Robinson urges medical staffs to bring these entrepreneurs back into the fold.

"There is an important role for these people to play now," he says.

Internal self-advocacy programs are yet another resource medical staff members can use, he points

out. Medical leaders can carry back thoughts and ideas from educational and informational programs on subjects ranging from AIDS to effective medical staff by-laws, then implement them in their own hospitals.

Specialty societies can also be a resource, he adds.

Even with help from outside sources, however, how effectively can medical staffs be managed — even led — by medical directors?

With medical directors, of course, comes that issue of divided loyalty, says Robinson. "In what direction *does* their loyalty lie? — Toward the medical staff, or toward the administration?" he asks. Too, medical directors are pressured by that inherent conflict between quality of care (their physician background) and the cost of that care (their new, administrative role).

Yet, divided loyalties and conflicting values may be moot in several years, Robinson points out, if the JCAH decides to eventually merge standards for the medical staff and the governing body.

"O'Leary thinks separate values are a mistake," says Robinson, who believes hospitals *may* be operating on the concept of an integrated hospital/medical staff relationship in the future.

"If this happens, then the traditional role of the medical staff and its principles as a self-governing body will be eroded."

In fact, Robinson adds, the role of the medical director is also

quite likely to lead to the erosion of the medical staff.

Can this erosion be prevented and the integrity of the medical staff retained?

Possibly, says Robinson. The election of effective medical leaders would help bring the focus back onto the staff. So, too, would beefed-up medical staff loyalty — a concept that often disintegrates as physicians divide themselves into conclaves, specialties and other factions.

"Physicians need to understand that their loyalty must be to the medical staff as a whole," Robinson says. "And everyone needs to display that loyalty."

Communication is yet another factor that could help prevent the erosion of today's medical staff.

"Most physicians lack communication skills," says Robinson bluntly, explaining that that is usually why it's difficult for medical staffs to reach a consensus among themselves, and why they have trouble articulating their position to the board.

"They need to sharpen their skills in this area," he says.

A cash flow position

Yet medical staffs do possess a strength that is often overlooked, he continues.

"The medical staff is the cash flow for the hospital," says Robinson. "If the board or the administration alienates its staff physicians, they may jeopardize that income."

Medical staffs need to reinforce that monetary strength to the hospital board, he comments.

"Medical staffs often view themselves as weak, and that's the image they present to the hospital board. But they are underestimating their power and influence in the marketplace," he adds.

Of course, hospitals try hard to foster that image. Private practitioners are made to feel as if they have no right to bargain — then, there is the practice that Robinson calls the "house office syndrome."

"Residents come into the hospital, and they're run around in circles for three years until a new group comes in," he says.

This way, they're kept off-balance and off-guard — never quite gaining the unity or strength they need to challenge hospital practice or authority.

How can physicians display their strength?

Get a bargaining chip, suggests Robinson.

"Put an option on buying land near the hospital. Spread the rumor that, unless things improve, you may have to throw up your own facility and steal 50 percent of the hospital's inpatient business.

"Hospitals lose money on the long stays, so if they think you're going to take their short-stay business away, they'll listen."

The idea, he continues, is to get the chips.

"If you don't have them, create them," he advises.

If nothing else, "chips" will get the hospital's attention — and restore some much needed parity in the hospital medical staff relationship.

Other steps the medical staff may want to take:

- Appoint a committee to set up management, or organizational goals.
 - Commit the staff's resources to maintaining quality care.
 - Raise the visibility of the medical staff. Find something to stand for — then do so.
 - Encourage participation of all members. "Courtesy privileges are not enough," says Robinson.
 - Ensure that the medical staff by-laws allow the staff to be self-governing.
 - Beware medical executive committees that may be construed as members of a special interest group, as opposed to a true representative body.
 - Ensure that the staff if managed by "duly elected leaders" as opposed to hospital "employees."
 - Ensure the staff's economic independence.
- "Most medical staffs don't have enough resources," says Robinson.

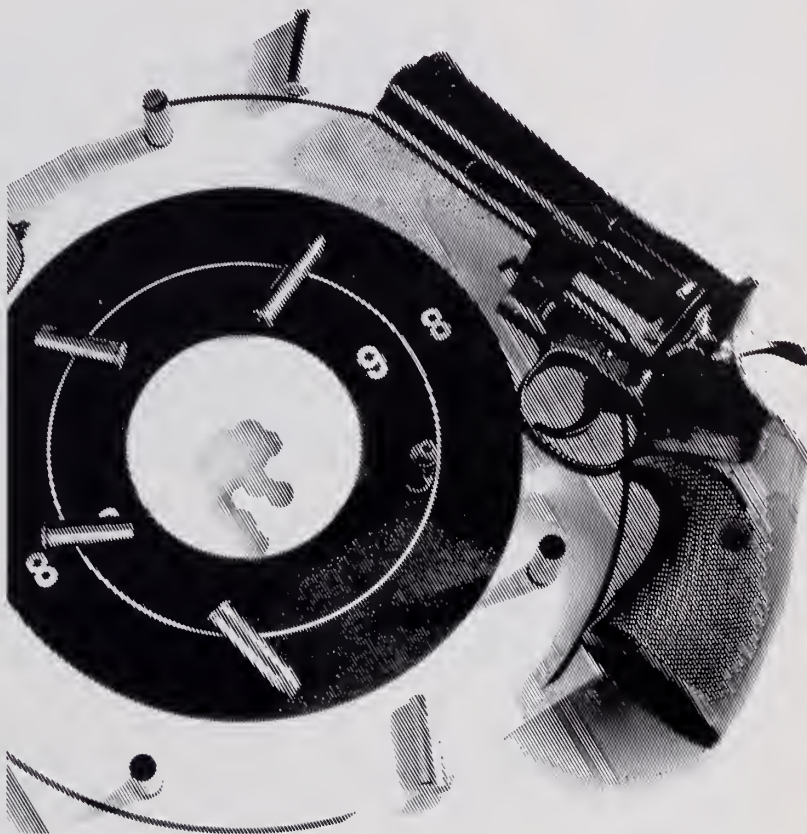
"They need to get some if they are to have any hope of remaining independent."

He suggests the possibility of medical staffs contracting with county and state medical societies to provide support.

"Why can't the medical staff coordinate their work through a medical society rather than through the hospital?" he asks. That way, the medical staff secretary or director of physician services, as they are more frequently being called, would be a person employed by the medical staff or the medical society, not the hospital.

"The idea needs some thought, but it's a real attention-getter," he says, adding, "It's quite likely that we'll see more novel and creative attempts to support medical staffs in the future."

And with that kind of encouragement — even the dinosaurs might have stood a chance at survival. **OSMA**



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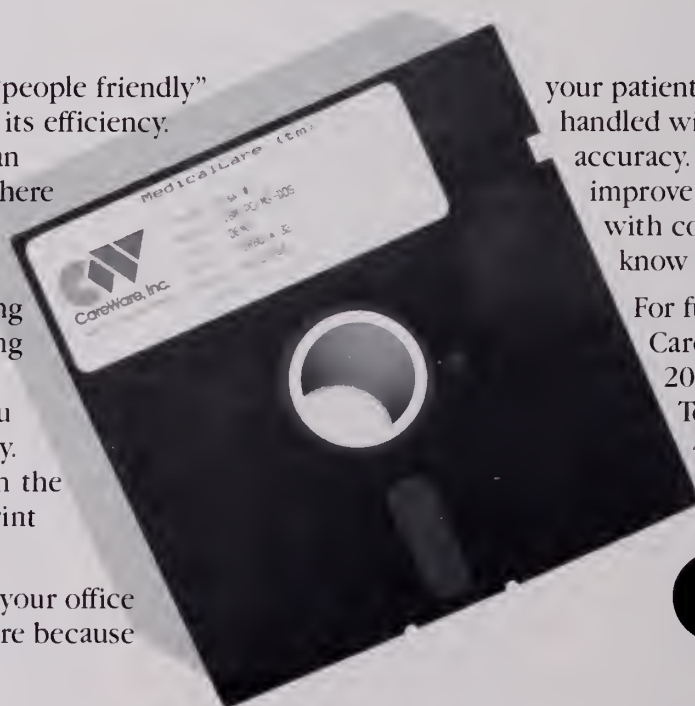
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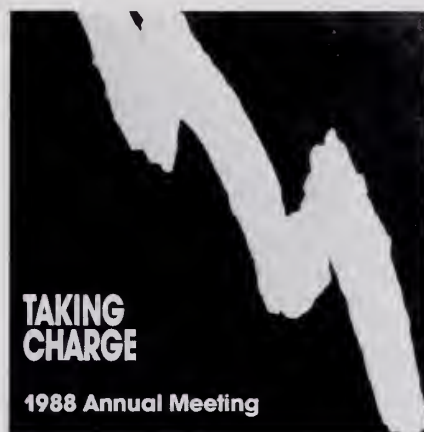
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The First Session of the House

By Karen S. Edwards

The message was nothing new. All year, OSMA President D. Ross Irons, MD, had been challenging Ohio physicians to "take charge for a change."

So, in mid-May, as over 200 delegates and alternate delegates to the OSMA converged on Cincinnati for the 1988 OSMA Annual Meeting, it was in that spirit of "Taking Charge" — the theme, incidentally, for this year's meeting.

Over 70 resolutions were brought before the delegates over the weekend-long event — tough medical issues to be pondered, discussed, debated. Donavin A. Baumgartner, Jr., MD, was installed as President during the House's Final Session, and William J. Marshall, MD, became the OSMA's President-Elect.

The House's opening session,

however, is traditionally a time for recognition — of both the progress and achievements that have taken place over the past year. This year's first session was no exception.

William Kitzmiller, MD, president of the Cincinnati Academy of Medicine began the Friday night proceedings by welcoming the delegates and making a few personal observations.

"Fifty years ago, my uncle, who was president of the Cincinnati Academy of Medicine, had some of the same concerns about medicine that we have today," he said.

"Third-party intervention, government regulation and other things continue to take the patient out of our reach. We need to get the patient back to center stage.

Hopefully, we can band together and organize ourselves so we can do this even more in the future," he concluded.

But guest John Clowe, MD, speaker of the AMA's House of Delegates stood before the House and hinted that getting the patient back to center stage would not be easy.

"Washington has five things on its mind today," he said. "Cost, cost, cost, quality and access to care."

Two recent government developments, in fact, are making the AMA Board of Trustees nervous, Dr. Clowe continued.

One of these is the relative value scale (RVS) which the Health Care Financing Administration (HCFA) is studying now for possible implementation into the government's Medicare program.

"Membership is still the name of the game. We must continue to maintain a strong, united front."

The RVS is presently a pilot study, being conducted at Harvard University. Before it's completed over 6,000 physicians will be asked about their fees for approximately 7,000 procedures. These relative value scales could then be implemented by HCFA as a reimbursement mechanism for Medicare — but *without* any input from the AMA, Dr. Clowe added quickly.

If implemented, "The question will naturally arise . . . what happens now?" said Dr. Clowe. No one knows yet, of course, but he pointed out that the U.S. might soon find itself in the same position as England, Canada and France, where a national health insurance system exists, and where each specialty decides what should be charged.

The second thing that makes the AMA Board of Trustees nervous is the mandated assignment of Medicare.

"The AMA is opposed to this," states Dr. Clowe, but 10 states have already passed legislation that will mandate physicians to care for low-income Medicare patients if they do not volunteer to do so.

"These are two of the main problems the AMA is working on now," says Dr. Clowe, "but there are multiple others. We are determining how best to remedy them."

Then, he echoed Dr. Kitzmiller's earlier sentiments about physician unity.

"If we don't unite and insist

upon quality care, we'll be failing ourselves, our profession and our patients."

Following Dr. Clowe's remarks, and the introduction of out-of-state guests and OSMA's past presidents, Thomas R. Leech, MD, Lima, approached the podium in his capacity as Chairman of the OSMA's Committee on Membership.

"Membership is still the name of the game," he told the House. "We must continue to maintain a strong, united front."

The good news, he said, is that at the end of 1987, the OSMA for the first time topped the 20,000-member mark with a total of 20,268 members.

"This increase in OSMA membership follows through in all categories," he continued, including the number of resident and medical student members, as well as those who have signed up for AMA membership. This last increase allows Ohio to continue its delegate strength at the national level, said Dr. Leech — yet, he continued, there is still room for improvement.

"Although 54 percent of our dues-paying members are members of the AMA, that still leaves many members who aren't," he says. In addition, approximately 3,000-4,000 physicians in Ohio belong to neither the OSMA or the AMA.

"And the number of our retired

members is steadily increasing — a trend that is likely to continue as liability and other factors force members into taking an early retirement. That situation, however, affects the amount of the revenue brought into the association," says Dr. Leech.

The Membership Committee continues to analyze these figures, and to monitor changing trends, said Dr. Leech, but he encouraged more active, aggressive recruitment of members in the future.

"We need to recruit new physicians in order to stop the erosion of organized medicine, and to preserve the excellence of the OSMA," he said. "The Outreach program (the OSMA's peer-to-peer recruitment program) is making a difference," he emphasized, "but we need to do more."

Claire Wolfe, MD, Columbus, received first-place honors for her recruitment efforts in the Outreach program for the second year in a row. Lewis Cavasa, Stark County, received second place, and George Ewing, MD, and David Spriggs, MD, both from Stark County, tied for third.

Carroll, Coshocton, Hancock, Monroe and Ottawa counties were also recognized by the House as having 100 percent OSMA membership.

An increase in membership is certainly a good indication that Ohio physicians are taking charge — but they aren't the only ones who are assuming a more assertive leadership role these days. So, too,

is the OSMA Auxiliary.

Although the Auxiliary's outgoing President Joyce Johnson was unable to attend the ceremonies in the Queen City, newly-installed President Cathy Stanton was escorted to the front of the House to present a brief report, and to assist Dr. Irons in distributing the AMA-ERF checks to representatives of Ohio's medical schools.

In her remarks to the delegates, she encouraged further development of the OSMA Auxiliary, and mentioned that the Auxiliary had worked hard this year to develop a membership pin.

She then turned to Dr. Irons.

"We would like you to have the first one," she said, attaching the small emblem to his lapel.

A total of \$75,585.81 AMA-ERF funds, collected by the Auxiliary, was then dispersed in the following manner:

Wright State	\$4,742.82
Case Western Reserve . . .	\$13,125.72
NEOUCOM	\$7,633.59
Medical College/Toledo . .	\$6,334.76
Ohio State University	\$22,774
University of Cincinnati .	\$20,973.97

Perhaps the highlights of the First Session came with the presentation of OSMA's Distinguished Service citation to Oscar Clarke, MD, Gallipolis.

Dr. Clarke was recognized for his years of active service to organized medicine, and to the OSMA in particular. His OSMA involvement has included terms as Councilor, OSMA President (1973-1974), Chairman of the Ohio Medical Education and Research Foundation (OMERF), and years of service as Chairman of the Ohio delegation to the AMA. Recently, Dr. Clarke was appointed to the AMA's Council on Ethical and Judicial Affairs, a singularly prestigious honor for which he was duly recognized by the House.



Dr. Oscar Clarke, his wife Susan beside him, receives the OSMA's Distinguished Service Award from Dr. Thomas Morgan.

In presenting the plaque to Dr. Clarke, Dr. Irons noted that the recipient was a leader and a statesman of organized medicine — "a doctor's doctor."

Dr. Clarke accepted the honor, saying that if he had been called upon to answer to criticism, he would do so.

"But when you praise me, I cannot reply," he said.

Plaques were then distributed to retiring council members, retiring members of the Ohio delegation to the AMA, and to retiring chairmen of various OSMA standing committees.

Janet Bixel, MD, Columbus, then approached the podium to present a short Medicaid update.

"We read in the papers about Medicaid's severe financial problems," said Dr. Bixel, "and we learn Medicaid payments may be cut. Right now, there are no plans to cut physician fees, or the drug formulary, but it could happen."

She pointed to a recent situation where HCFA decided not to pay for brand-name drugs in the cardiac and psychiatric field.

"The biggest problem was with the anti-convulsants and their generic substitutes," she says.

Because the generic drugs were creating problems for patients, the physician community responded with letters to HCFA, requesting that the brand-name drugs be returned to the formulary.

"They were returned, and will be dispensed if the prescription carries DAW in your own handwriting," says Dr. Bixel, adding, "Despite Medicaid's financial problems, we'll try to keep anti-convulsants on the list."

Unfortunately, however, anti-convulsants are the only brand-name drugs that can be returned to the formulary.

"We can't overrule HCFA on the rest. You still need to get prior authorization if you want to order a brand-name drug, and as those who deal with Medicaid know, this can be an impossible nightmare. But, with the current Medicaid problem, we may be stuck with this," she says.

She concluded by saying she doesn't have all the answers.

"I would appreciate any suggestions and help you can give me with this, because we're going to have to work together if we're going to keep quality care and quality medicine for our patients."

Of course, any president's year in office is not officially over until he (or she) has had an opportunity to reflect on where they've been, and what they've done while guiding the helm.

In his presidential address, D. Ross Irons, MD, proved to the House over and over again that he was, indeed, a leader who could "take charge for a change."

"I promised, when I took office last year, to stand before this House and give a full accounting of my year as President," said Dr. Irons.

"I promised then that the leadership and staff of OSMA would be dedicated to the notion of being in charge for a change, by taking charge of medicine's changing environment. I am here to report that we have kept that

promise," he continued.

He pointed to Ohio's impressive legislative track record, citing physician involvement in OMPAC as a significant factor in the association's legislative success.

"Membership has increased dramatically, but we are still woefully short of what is needed for impact in the legislature," he said.

He did, however, point to the successful passage of tort reform legislation this year, adding, "that's something we should be proud of."

He was eager, however, to point to other achievements — to issues that the OSMA, under his administration, had taken a proactive stance on this year. For example:

- Medicare "Medical Necessity" letters. OSMA was on the verge of filing a legal action against HCFA when HCFA offered a compromise.
- Ohio Project Elderly Needy (OPEN). This is OSMA's program at the county medical society level which impacts positively on the physician-patient relationship.
- Reactivated Cancer Committee. The Committee has developed a cancer checklist for physicians' offices and guidelines for cancer screening centers.
- AIDS Task Force. These dedicated physicians have addressed the issue in a calm and rational manner to the Ohio General Assembly, the membership, and to the public.
- Public Relations. OSMA prepared and disseminated a series of brochures on socioeconomic issues for patients.
- Ombudsman. This program helps individual physicians with reimbursement problems, as well as addressing broader issues

with Medicare, Medicaid, workers compensation, and other government medical programs.

He singled out for special recognition the Ohio Delegation to the AMA, whose members he called "efficient and well thought-of." He applauded the chairmen of OSMA's committees, and the work of all committee members, as well as the recruitment of young physicians into the organization.

His administration was not without its dark clouds, however.

A pending problem, said Dr. Irons, is a division in medicine's rank, brought on by the turf-protective specialty societies.

"We must ultimately work together," he said, "for divided we fall — and both we and our patients will suffer."

He briefly discussed the budget process, noting that, in light of all of OSMA's activities, a dues increase had become mandatory — just as a lack of office space has necessitated a move of OSMA headquarters to 1500 Lake Shore Drive.

He next addressed the subject of PICO, stating that it had emerged from its recent crisis as a "lean, mean company with adequate reserves . . . and more able to meet the demands of the marketplace."

He admitted, however, that his year also had its disappointments.

Dr. Irons had hoped, for example, for more activity with the academic world, "for it's apparent that town and gown must live together" — and he had hoped to attend more medical staff meetings around the state, "to expand our solidarity," he noted.

But, overall, Dr. Irons expressed few regrets.

In looking toward the future, he said that medical societies need to more closely examine their

purpose, then prioritize their resources in accordance with that purpose.

He also advocated future strengthening of the physician-patient relationship.

"With education, we can help patients understand we are their best, their most loyal advocates."

He concluded by saying:

"The success of the programs we've implemented can only be judged over time. I hope, however, that each of you experiences the satisfaction of defining your own challenges, and that you have the opportunity to be in charge for the right change."

The House then considered two memorial resolutions — both for former medical society executives who died over the past year. One was Robert Lang, former Executive Director of the Cleveland Medical Society; and the second was Charles Nelson, past Executive Secretary of the Ohio State Medical Association.

In its final business, the House recognized and presented a plaque to OSMA Executive Director, Herb Gillen, for 25 years of service to the Association. **OSMA**

Karen S. Edwards is the Executive Editor of OHIO Medicine.



D. Ross Irons, MD, presents the House with an accounting of his year as President.



In its final business, the House recognized OSMA Executive Director Herb Gillen for 25 years of service to the Association.



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The Final Session of the House

By Deborah Athy

Of the more than 70 resolutions considered at the 1988 OSMA House of Delegates in Cincinnati, the topic that prompted the most voluminous response came as no surprise.

The topic was AIDS, and by the session's end, the OSMA delegates had analyzed, refined, and adopted a comprehensive AIDS resolution that addressed such issues as anonymous testing centers, informed consent and voluntary testing.

But the delegates had many other issues on their agendas as well — everything from Medicare, living wills and pharmaceutical advertising to modifying the balloting procedure at the Final Session of the House of Delegates.

Before the microphone debates could get under way, the Credentials Committee reported that 225 (out of a possible 256) Ohio delegates were present.

The House recognized the 100th anniversary of the Greene County Medical Society with a plaque and

a centennial resolution. The resolution recognized the contributions of past and present GCMS members to the quality of medicine.

The next order of business was the election of the OSMA President-Elect. Although both candidates, William J. Marshall, MD, of Dayton, and Thomas Leech, MD, of Lima, were highly recommended by their peers, Dr. Marshall was declared the OSMA President-Elect for 1988-89. He offered a few words of thanks —



Delegates line up to register, just before the Final Session of the House.



Impromptu conferences are common before the House is called into session.

to Dr. Abromowitz and the Second District, and to his wife and daughters, whom he called "an elegant infrastructure for any candidate."

Joseph Sudimack, Jr., MD, of Columbus, was elected to a second term as OSMA Secretary-Treasurer, and Audrey Ludwig, of Cincinnati, was elected Medical Student Section Alternate Delegate to the AMA.

Resolutions Committee #1 reports

The first resolution of the night, which proposed that delegates submit a completed ballot in election procedures, prompted some debate on the floor of the House.

Thomas W. Morgan, MD, OSMA past-president, reported that a committee of past-presidents created the resolution for the purpose of speeding up the voting procedures at the House of Delegates.

While the voting procedures that afternoon went off without a hitch (the Delegates unanimously accepted the Nominating Committee's report — see sidebar), the vote casting has not been as expedient in years past.

Dr. Morgan said the completed ballot procedure is used in the AMA, and he strongly recommended that "Ohio . . . get into the swim of things with the rest of the nation" by adopting the resolution.

But another past-president, John Gaughan, MD, took a contrasting point of view. He perceived the procedure as a "perversion of the democratic process," in which the poorest candidate could get elected. Although voting can sometimes be inconvenient and cumbersome, he said, "This is a minor problem compared to the philosophical" implications of the resolution.

Both points of view had supporters. William Porterfield, MD, Tenth District, spoke in favor of the resolution, saying, "If we don't have good candidates, it's the fault of the nominating committee, not balloting."

Claire Wolfe, MD, Tenth District, viewed the resolution as a more efficient method of voting, rather than a democratic encumbrment.

But others opposed the resolution, stating, "The more we appoint rather than elect, the more we refer to Council, the less grassroots representation we get."

And George Ewing, MD, Stark County, presented his feelings this way: "If it ain't broke, don't fix it. We don't want to be forced to vote for someone we don't want to vote for."

After all was said and done, a written vote was requested — the voice and hand votes were too close to call — and Resolution 01-88 was adopted by a narrow majority.

Membership dues: increases and reductions

Resolution 03-88 called for a \$100 increase in the annual dues for OSMA members. The resolution moved quickly through the House, although in reference committee the previous day a few objections were raised. One physician preferred that the increase be staggered (as the original resolution proposed) over several years, because he worried that his county members would not accept the increase.

But Stanley Lucas, MD, Cincinnati, said the House should pass the resolution, in order to avoid repeatedly coming back to the House for additional increases.

Dr. Sudimack pointed out, "There is no free lunch. The (OSMA) staff-member ratio is the lowest in the country."



Resolutions Committee #2 considers carefully the testimony presented during the morning hearings.

And Donavin Baumgartner, Jr., MD, added his thoughts: If we don't pass an increase, what services should we cut?

Resolution 05-88 called for a reduction in dues for physicians in their second year of practice. Some of the members suggested that the reduction should only be given by request — an idea that was incorporated into an amendment. Dr. Leech pointed out that the proposed policy brought the OSMA in line with the AMA. In Reference Committee, Dr. Wolfe spoke in favor of the resolution, pointing out that the OSMA should seek "anything creative we can do to increase membership among young salaried physicians." The amended resolution was adopted.

A similar resolution proposed a

reduction in dues for physicians over age 65. Dr. Clarke opposed the resolution, saying it "advances the philosophy that age justifies a discount." And Dr. Ewing pointed out, "If anyone should be able to pay dues at age 75, it's the physician. Let me pay my dues," he said.

But other delegates supported the resolution as a "reward for long years of membership." Eventually, an amendment was passed, which made the reduction available at the *request* of the over-65 physician, and the resolution was adopted.

The resolution that called for a reduced dues structure for physician couples was referred to Council. Reference Committee #1 was divided on the issue and suggested that a pilot program be

set up to shed some light on the subject.

The House adopted Resolution 08-88, *Resolutions by Hospital Medical Staff*, and 09-88, *Hospital Medical Staff Section Councilor*. An HMSS spokesperson said that allowing the HMSS to submit resolutions would enable the OSMA to analyze pertinent concerns of the HMSS. In addition, the election of an HMSS Councilor is an "efficient means of communication between the OSMA Council and the HMSS physicians."

Medicare issues

Next, the House considered Resolutions, 13, 14, 15 and 24-88, all addressing Medicare's Medical Necessity Program. As one of the delegates pointed out, Medicare "is one of the most important issues that we have come to Cincinnati to discuss."

Reference Committee #1 recommended that these complex, interrelated resolutions be referred to Council. The resolutions were drafted in response to Medicare health insurance letters sent by Nationwide Insurance that stated that services provided to Medicare-covered patients were medically unnecessary. Many of the delegates said the OSMA should do everything legally possible to stop the "harassment." The House referred the resolutions to Council for action.

Other Medicare-related resolutions included: 16-88, calling for more Medicare information to be included in the *OSMAgram* (adopted); and 19-88, calling for an independent study of Mandatory Medicare Assignment (rejected). Opponents said the OSMA should wait for the results of Ohio H.B. 150 before launching a study.

Resolution 20-88, dealing with

Medicare Reimbursement, proposed that the OSMA and AMA demand that the HCFA allow physicians to practice high quality medicine, expect a reasonable fee for service, and receive payment in multiple consultations.

Dr. Wolfe summed up, "This is an issue of concurrent care. We should take this to the national level."

Frederick T. Suppes, MD, Fifth District, stressed that physicians must take the issue back to patient quality care rather than the pocketbook. "If we can get patients to understand this, we're going to have strong allies." The resolution was adopted, and then referred to Council for analysis and action.

Other resolutions adopted by the House proposed that the OSMA:

- charge a \$10 fee for OSMA publications to retired members in order to comply with second class postage regulations if a survey shows the need for such a step.
- promote a modified Project Open program statewide as a voluntary alternative to Mandatory Medicare Assignment.
- support legislation that would make it mandatory for employers to offer health insurance coverage options.
- work with insurance companies to coordinate third-party payment notifications.

Some resolutions referred to Council included: licensure of medical review agencies and medical necessity decisions.

The next order of the day was the installation of Donavin A. Baumgartner, Jr., MD, Cleveland, as OSMA president.

Dr. Baumgartner's wife Marilyn, and family, including sons Peter and Donavin III and their spouses, and grandchildren Donavin IV and

Erica, were escorted to the podium.

Dr. Albers installed Dr. Baumgartner as the new OSMA president. D. Ross Irons, MD, was presented with the past-president's pin and plaque, and the Presidential Medallion was presented to Mrs. Irons.

Dr. Baumgartner then addressed the House, pointing out that in these volatile times, physicians need only ask themselves one question when faced with medical or ethical decisions: *Is this in the interest of my patient?* If the answer is yes, he said, there need not be any hesitation. "For whatever is good for the patient will be good for the profession." (See Dr. Baumgartner's complete Presidential Speech included in this issue.)

Resolution Committee #2 reports

One of the repeated topics in the Reference Committee #2 resolutions regarded living wills. Substitute Resolution 33-88 (replacing No. 33, 34, 48, 49 and 50), *Living Wills and Durable Power of Attorney for Health Care in the State of Ohio*, called for the OSMA to actively assist Ohio legislators as they consider legislation recognizing living wills and durable power of attorney and to support legislation that:

- identifies the right and responsibilities of adults who wish to make a living will.
- establishes immunity from civil and criminal prosecution for physicians who comply with living wills or durable power of attorney instructions.
- recognizes that some physicians are ethically restrained from complying with these instructions.
- establishes immunity for those physicians who refuse to comply and provides that these physicians not interfere with

An Overview of Actions on Resolutions

Committee #1					
01-88	Requiring a Completed Ballot — Adopted	18-88	Voluntary Acceptance of Medicare		Residency Programs — Adopted
02-88	Single Shot Voting — Rejected		Assignment Through Modifications of Project OPEN — Adopted	32-88	Young Physicians as Delegates and Alternate Delegates — Adopted
03-88	Dues Increase — Adopted	19-88	Independent Study of Mandatory Medicare Assignment in the State of Ohio — Rejected	SR 33-88	Living Wills and Durable Power of Attorney for Health Care in the State of Ohio (Replacing No. 33, 34, 48, 49 & 50) — Adopted
04-88	Spouse Active Membership — Referred to Council	20-88	Medicare Reimbursement — Adopted	35-88	Oppose Voluntary Active Euthanasia (Mercy Killing) — Adopted
05-88	Reduction of Dues for Physicians in Their Second Year of Practice — Adopted	21-88	Employees Right to Choice of Health Insurance Option — Adopted	36-88	Health Insurance for New or Improved Modalities — Adopted
06-88	Dues Reduction for Physicians Over 65 with Reduced Practices — Adopted	22-88	Licensure of Medical Care Review Agencies — Referred to Council	37-88	Infertility Insurance Coverage — Adopted
07-88	Publications Charge to Retired Members — Adopted	23-88	Maintain Physician Authority in Determining Medical Necessity — Referred to Council	38-88	Organ Harvesting From Nonviable Fetuses — Adopted
08-88	Resolutions by Hospital Medical Staff — Adopted	24-88	Class Action Suit Against Medicare Carrier — Referred to Council	SR 39-88	Hospital Advertising (Replacing No. 39 & 40) — Referred to Council
09-88	Hospital Medical Staff Section Councilor — Adopted	25-88	Federal PRO — Adopted	41-88	Reporting Physician's Restriction of Privileges — Rejected
10-88	Safeguard Confidentiality of PRO Records — Adopted	26-88	Third-Party Payor Responsibility Act — Adopted	42-88	Association Liability Insurance — Adopted
11-88	Health Insurance Company Evaluation — Rejected	27-88	Uncompensated Service to Third-Party Payors — Rejected	43-88	Protection of Pension and Profit-Sharing Funds — Adopted
12-88	Third-Party Physician Payment Notification — Adopted			SR 44-88	Awareness of Participating Providers (Replacing 44-88) — Adopted
13-88	Medicare, Medical Necessity — Referred to Council	Committee #2			AMA Lobbying — Rejected
14-88	Medically Unnecessary Services Letter — Referred to Council	28-88	Resolution of Commendation: Oscar W. Clarke, MD — Adopted	45-88	Statute of Limitations — Withdrawn
15-88	Medically Unnecessary Services — Referred to Council	SR 29-88	Limitation of Resident Work Hours (Replacing No. 29 & 30) — Adopted	46-88	Cooperation in Medical Care — Adopted
16-88	A Monthly Medicare Newsletter — Adopted			47-88	Standardized Definition of Emergency — Adopted
17-88	Withholding of Political Contributions — Rejected	31-88	Parental and Sick Leave Policies in	51-88	

the timely transfer of patient care to another physician.

The resolution was amended to note that the OSMA will *support* this type of legislation. "OSMA has never gone on record supporting this before," Dr. Wolfe said. The House then adopted Amended Substitute Resolution 33-88.

Reference Committee #2

recommended referral of Resolution 35-88, which called for opposition to voluntary active euthanasia, but some delegates wanted to take prompter action. A Fifth District delegate pointed out that a great deal of confusion existed about the issue. "A clear statement from the OSMA would do a great deal to clear the air," he said.

Another delegate reported that because there are two bills currently before the Ohio House of Representatives regarding this issue, the OSMA should go on record regarding this timely topic. The House voted to adopt the resolution opposing legislation that legalizes mercy killings.

Another newsworthy ethical issue is that of organ harvesting; the recent case of an organ donation from an anencephalic infant has caused an ethical uproar and media blitz. The House adopted Resolution 38-88, which asks the AMA to establish ethical guidelines that address the use of prenatal diagnoses results and organ harvesting. Dr. Clarke commended the Medical Student Section for bringing this issue to the attention of the House.

Another delegate applauded the authors of Resolutions No. 29 and 30, which call for the limitation of resident work hours. The adopted resolutions are "important to ensure and maintain quality education," said one physician.

- Other adopted resolutions call for the OSMA to:
- express support for parental and sick leave in residency programs.
 - urge county medical societies to select qualified young physicians to serve as OSMA delegates and alternate delegates.
 - encourage the AMA to give insurance companies a summary statement of the proved and improved modalities for screening, diagnosing or treating disease in order to get insurance coverage.
 - encourage third-party payers to provide coverage for diagnosis and treatment of infertility.
 - make an effort to align medical staff, hospital medical administrators and nursing staff.
 - support legislation exempting

Overview of Action . . . continued

Amended Report A	Committee to Review OSMA House of Delegates Policy — Adopted	63-88	Professional Time to Poor — Adopted
ER 04-88	Physician Peer Review Antitrust Protection — Adopted	64-88	Relationships of Physician With Managed Health-Care Plans — Referred to Council
ER 05-88	Peer Review — Rejected	65-88	State Medical Board Guidelines — Adopted
Committee #3		66-88	Autopsy Increase — Adopted
SR 52-88	Sex Education in Public Schools (Replacing No. 52 & 53) — Adopted		Amending Hospital Staff Bylaws to Provide for the Right to Legal Counsel — Referred to Council
SR 54-88	AIDS Policy (Replacing No. 54 & 55) — Adopted	67-88	Peer Review of Fees — Adopted
56-88	Universal Immunizations — Adopted	68-88	Public Education on Hazards of Tanning Parlors — Adopted
57-88	American Pharmaceutical Association — Adopted	69-88	Expediting Communications for Freedom — Rejected
58-88	Oppose Pharmaceutical Advertising — Adopted	70-88	Violence in Movies, Television and Videotapes — Adopted
59-88	Drug Paraphernalia — Adopted	71-88	Helicopter Ambulance Safety — Rejected
60-88	Optometric Use of Drugs — Adopted	SER 02-88	Nursing Shortage — Implementation of American Medical Association Board of Trustees Report CC I-88 (Replacing No. 02 & 03) — Adopted
61-88	Post-operative Ophthalmic Care — Referred to Council		
SR 62-88	Donation of		

pension and profit-sharing funds from seizure in malpractice judgments.

- request the AMA to develop a standardized definition of an "emergency."

A resolution from the Consent Calendar that met with no resistance was one commending Dr. Clarke for his many years of service to the OSMA. "Dr. Clarke has consistently been a patient advocate, embodying most keenly the true meaning of being a physician," the resolution stated. The resolution also commended his "insightful and creative" leadership as OSMA president, Chairman of the Ohio Delegation to the AMA, member of the AMA Council on Ethical and Judicial Affairs, and AMA Delegate. Dr. Clarke received a Distinguished Service Award at the First Session of the House of Delegates.

Resolutions Committee #3 reports

Next, Reference Committee #3 resolutions were brought before the House. The first order of business was Substitute Resolution 52-88, *Sex Education in Public Schools* (replacing No. 52 and 53). In reference committee the previous day, a physician said, "We as physicians should come out loud and clear that we are behind health education."

S.R. 52 proposed that the OSMA support H.B. 345, which requires the board of education of each county, village or city school district to prescribe a course of study that covers such topics as STDs, AIDS prevention and comprehensive sex education.

But some delegates argued that, "If you leave it up to each county, you may still have insufficient education. There may be a discrepancy in what is taught."

The Medical Student Section



William J. Marshall, MD

Election Results

President-Elect — William J. Marshall, MD, Dayton, was elected President-Elect of the OSMA in the Final Session of the House on Sunday, May 22.

Secretary-Treasurer — Joseph Sudimack Jr., MD, Columbus, was re-elected to a second term as Secretary-Treasurer of the OSMA. Councilors from odd-numbered districts were up for re-election during the meeting. The following Councilors were elected:

First District — **Stanley J. Lucas, MD**, Cincinnati, re-elected.

Third District — **William H. Kose, MD**, Findlay, replacing Thomas Leech, MD.

Fifth District — **Henry G. Krueger, MD**, North Olmsted, re-elected.

Seventh District — **Nermin D. Lavapies, MD**, Martins Ferry, re-elected.

Ninth District — **Richard Villarreal, MD**, Wheelersburg, replacing Thomas R. Price, MD

Eleventh District — **Charles G. Adams, MD**, Vermilion, re-elected.

In addition, **Walter A. Reiling, Jr., MD**, Dayton, was elected as Second District Councilor to fill the spot created by Dr. Marshall's election as President-Elect. **Richard Steinman**, Medical College of Ohio, was elected President of the OSMA Medical Student Section and **Louis A. Cannon, MD**, Akron, was elected Chairman of the Resident Physician Section. Mr. Steinman and Dr. Cannon will

sit on the OSMA Council.

AMA Delegates — The following physicians were elected as Delegates to the American Medical Association (terms January 1989 to December 1990 unless indicated):

Herman I. Abromowitz, MD, Dayton

Donavin A. Baumgartner, Jr., MD, Cleveland (May 1988 to December 1990)

Theodore J. Castele, MD, Cleveland

Roland A. Gandy, Jr., MD, Toledo

Jerry L. Hammon, MD, Dayton

Stanley J. Lucas, MD, Cincinnati

Thomas W. Morgan, MD, Gallipolis

Richard J. Nowak, MD, Cleveland

H. William Porterfield, MD, Columbus

S. Baird Pfahl, MD, Sandusky

AMA Alternate Delegates — The following physicians were elected Alternate Delegates to the AMA (terms January 1989 to December 1990):

Edmund C. Casey, MD, Cincinnati

Jerome Kimmelman, MD, Toledo

Henry G. Krueger, MD, North Olmsted

William J. Marshall, MD, Dayton

Raymond J. McMahon, Jr., MD, Massillon

Walter A. Reiling, Jr., MD, Dayton

Lee J. Vesper, MD, Cincinnati

In addition, Audrey Ludwig, Cincinnati, was elected by the OSMA Medical Student Section as an Alternate Delegate for one year commencing February 1988.



D. Ross Irons, MD, recognizes a delegate wishing to testify.



The front of the House listens to a point being discussed on the floor.

then proposed an amendment requesting OSMA Council to implement a standardized sex education program. Some delegates regarded this concept as controversial, pointing out that such a program could be “unpalatable” in some provincial areas.

But Dr. Ewing, who described himself as a former president of a “provincial” school district, said, “We would welcome any help.” He added that physicians must offer their expertise in the implementation of sex education programs.

The House adopted the amended resolution.

The AIDS debate

The lengthy debate in reference committee regarding two AIDS resolutions set the stage for continued discussion on Sunday. Stanley Fox, MD, pointed out that society and the medical community are facing a major test. “If we don’t pass it, history will not treat us kindly.”

Much of the discussion in reference committee focused on three primary issues: voluntary vs. mandatory testing; informed consent; and confidential vs. anonymous testing.

“Physicians are in a quandary about who should be tested. We need some clear, coherent perspective,” stated one physician. “These resolutions call for the OSMA to develop a policy and review the AMA policy.”

The most heated debate in reference committee concerned anonymous testing sites. Dr. Fox, for example, opposed anonymous testing and favored strict confidentiality. “We have to go by what we did before with other diseases,” he said.

But according to Thomas Halpin, MD, of the Ohio

Department of Health, what was adequate for other diseases is not necessarily appropriate for AIDS. Certainly there are similarities between AIDS and diseases of the past, he said, but there are also distinct differences.

"AIDS has to be looked at as its own entity. We see it is essential to do anonymous testing. The whole thing is to get high-risk individuals into testing. They won't get into the system if they think their confidentiality is going to be divulged. If we disallow anonymous testing," he continued, "it makes it more difficult to reach those we want to hone in on."

A physician from a rural community said that in a small town, confidentiality is next to impossible. For that reason, he said, anonymity is imperative. In addition, he added, "We should assume that everyone is positive and always use proper precautions."

William Keck, MD, Director of the Akron Health Department, concurred. He pointed out that anonymous testing sites are trying to expand their contact tracing system and testing of high-risk persons. "We've been working to gain the trust of high-risk groups. We now have the confidence of the community and we don't want to lose it."

But according to Dr. Fox, maybe the trick is to eliminate the *stigma* of ordering AIDS tests. With an estimated 1.5 to 3.5 million HIV-infected persons in this country, "We should be making it easier to order tests for AIDS, not more difficult." Regarding the financial concerns of increased AIDS testing, he said, "By the time it's cost-effective, it will be too late. Cost of testing is a moot point considering the cost of the disease."



Delegates relax between committee reports.



Reference Committee #1 — presents its report before the House.



William C. Miller, MD waits for his turn to speak at microphone #3.



Fred Suppes, MD, makes his point before the House.

Other comments touched upon the importance of education ("Even though it's not the greatest, it's the only thing we have") and counseling ("really an adjunct to testing").

With all of these issues to consider — and many others that weren't even discussed — Reference Committee #3 had its hands full. But by the next day it presented S.R. 54 (replacing No. 54 and 55) to the House.

A delegate quickly recommended that each resolve — 15 of them in all — be considered separately, and the motion was passed.

Ed Gardner, MD, District 10, proposed an additional resolve that stated that the OSMA recognize that the confirmed positive HIV individual has an infectious disease. The House passed the amendment as the first resolve.

The Fifth District proposed that a physician who reports the names of individuals who test positive for HIV be immune from liability. The amendment passed.

Anonymous testing sites and AIDS reporting

Another proposed amendment said that physicians at anonymous testing sites should be immune from reporting HIV individuals. Dr. Keck supported the amendment, explaining that anonymous testing has enabled the number of individuals being tested to double in the past year.

Jack Summers, MD, a member of the OSMA AIDS Task Force, also spoke in favor of the amendment. "Anonymous testing provides inroads to the high-risk population. Demanding that physicians report at anonymous testing sites will be cutting off our only avenue to get to these individuals."

But others, such as W. Jeanne McGibbons, MD, reference committee member from Lorain

County, spoke against the amendment; she said that in terms of overall public health, reporting is more important than protecting the identities of the patients.

Dr. Summers pointed out that anonymous testing is not a matter of trying to shield a high-risk group, but is a mechanism to reach them.

Dr. Fox likened the AIDS situation to syphilis, stressing that, "Reporting is the cornerstone of any infectious disease. We'll be held to account for not standing for strict confidentiality rather than anonymous testing," he predicted.

But Dr. Summers suggested that, "Reporting didn't make a difference in syphilis, treatment did."

Questions were then raised about the effectiveness of contact tracing. "What percentage (of HIV-tested individuals) are submitting to contact tracing?" asked a 10th District delegate.

In response, Dr. Keck estimated that about half were participating in contact tracing, but added, "We are pushing that more than we have before."

Dr. Davies urged the House to listen to the reiterated facts from those in metropolitan areas. "We really have to take the words of those working in the trenches. If those people tell me that's how we should do it . . . (then) we should respect their expertise."

The resolution was eventually amended so that anonymous testing centers would not be required to set up code systems for retrieval of the identity of confirmed HIV individuals. However, the centers should continue to encourage HIV patients to contact their partners for further testing, the resolution stated.

AIDS testing

More debate then ensued regarding the ordering of HIV tests and the question of informed consent. An amendment was proposed that stated that no more permission should be needed to perform an HIV test than any other test. But Dr. Summers viewed this approach as a breakdown in communications between physician and patient. "Physicians can approach patients by saying, 'I'm concerned about AIDS. Let me do a test.'"

Dr. Lucas opposed the amendment because he said the original resolve contained enough of a caveat to protect the physician, stating that the physician should obtain informed consent "unless the test is medically necessary to avoid or minimize immediate danger to the health or safety of the patient or another individual."

When asked for a legal opinion, Dr. Kose noted that there could be legal problems if there is no informed consent. The amendment failed.

Another resolve meeting with some discussion concerned insurance companies and AIDS. The original resolve said that insurance companies have the right to order HIV tests before issuing policies; however, once the patient has insurance, the company cannot cancel or refuse to renew the policy based solely on the fact that the patient has AIDS.

A delegate objected to the implication that insurance companies *have the right* to order HIV tests, and instead suggested amending the wording to say that the insurance company *may have the right* to order tests. The amendment was passed.

As an aside, Dr. Davies, of Nationwide Insurance, pointed out, "If risk cannot be differentiated,

then the cost of AIDS will be spread across all groups. We're all going to be paying the premiums."

After much discussion and many trips to the microphones, S.R. 54-88 was adopted by the House of Delegates (see complete resolution in the minutes), thus becoming the OSMA's most comprehensive AIDS policy to date. An additional resolve was approved to forward the resolution to the AMA in June.

Next, the members of the House discussed Resolution 58-88, Pharmaceutical Advertising. In reference committee the previous day, videotapes were shown of commercials that advise consumers to *see your doctor and ask about these medications*.

The resolution suggested that the OSMA adopt a policy of opposition to this type of pharmaceutical advertising. The reference committee, however, recommended rejecting the resolution — partly because there are no legal means to stop the advertising, and partly due to the rationale that these messages might encourage more patients to seek medical care.

But a District Two delegate cautioned that this type of advertising was just the tip of the iceberg. He suggested that a vote for the resolution would send a clear message to the pharmaceutical companies. "The products on TV under the guise of public education will cause confusion. It's time to take a stand," he said. "We should protect the patient."

The Medical Student Section also spoke in favor of the resolution, saying that in the long run, the ads were counterproductive, both financially and as educational tools.

After repeated support, the resolution was adopted.

Dr. Wolfe, chairman of the



While the House recesses, a delegate takes time to look at the exhibit put together by OSMA's Department of Communications.



As Immediate Past President, D. Ross Irons, MD, tries on the accouterments of his new "pastime" — a gentleman farmer.

ONA-OSMA Task Force, spoke in favor of Substitute Emergency Resolution 02-88, which resolved, in short, to improve dialogue with the ONA and work to increase enrollment in nursing education, in order to alleviate the nursing shortage.

Dr. Wolfe explained that the resolution also seeks to implement the AMA's Board of Trustees Report on Nursing CC I-88, which attempts to make the nursing profession more attractive and opposes the creation of another category of caregiver in an attempt to rectify the situation.

Dr. Irons also spoke in favor of the resolution in reference committee the previous day. Substitute Emergency Resolution 02-88 was adopted by the House.

Some of the other Reference Committee #3 resolutions adopted by the House resolved that the OSMA:

- continue to donate time to the poor.
- promote universal immunizations for children.
- request that the American Pharmaceutical Association notify its members that prescriptions be refilled only by a physician's order.
- support and/or develop legislation that addresses the sale and manufacture of drug paraphernalia.
- oppose optometric authorization to prescribe drugs.
- work against violence in the media.
- warn against the hazards of tanning parlors.

Resolutions referred to Council included those dealing with post operative ophthalmic care, managed health plans, and changing hospital staff bylaws to allow for the right to legal counsel. **OSMA**

**THE 1988 ANNUAL MEETING PROCEEDINGS OF THE
OSMA HOUSE OF DELEGATES**

**MINUTES OF THE
FIRST SESSION**

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7:10 p.m., Friday, May 20, 1988 at the Cincinnati Convention Center (Room 210), Cincinnati, with the President, D. Ross Irons, MD, presiding.

Dr. Irons announced the Presentation of the Colors by the 237th Calvary Regiment, Troop A, followed by the Pledge of Allegiance. Dr. Irons thanked the 237th Calvary Regiment for its participation.

The invocation was offered by Charles G. Adams, MD, Vermilion, Eleventh District Councilor of the OSMA.

Dr. Irons introduced others seated at the Speakers Table, as follows: Joseph Sudimack, Jr., MD, Columbus, Secretary-Treasurer; John E. Albers, MD, Cincinnati, Immediate Past President; W.J. Lewis, MD, Dayton, OSMA Parliamentarian; D. Brent Mulgrew, JD, Managing Director; Herbert E. Gillen, Executive Director; Donavin A. Baumgartner, Jr., MD, Cleveland, President-Elect; Charles G. Adams, MD, (already introduced); and K. William Kitzmiller, MD, Cincinnati, President of the Academy of Medicine of Cincinnati.

Dr. K. William Kitzmiller welcomed the delegates, alternate-

delegates and guests to Cincinnati on behalf of the Academy of Medicine of Cincinnati. He reminded the audience to make the patient's needs "first" as they considered the issues at this Annual Meeting.

**REPORT OF THE
CREDENTIALS COMMITTEE**

Janet K. Bixel, MD, Franklin County, Chairman of the Credentials Committee reported that of 256 members eligible to attend and vote, 190 were present.

A number of alternate delegates, guests, officers of county medical societies and medical society executives were in attendance.

1987 MINUTES APPROVED

The minutes of the 1987 sessions of the House of Delegates, as published in the August issue of *OHIO Medicine* were approved by official action.

**INTRODUCTION OF MEMBER,
AMA BOARD OF TRUSTEES**

Dr. Irons introduced Dr. John L. Clowe, Schenectady, New York, Speaker of the AMA House of Delegates. Dr. Clowe discussed mandatory assignment and relative value scales and other issues facing organized medicine.

Dr. Irons recognized Dr. Ray W. Gifford, Jr., Cleveland, a member of the AMA Board of Trustees.

Dr. Irons also recognized Cindy Meehan, Membership Development Executive of the American Medical Association and Ms. Nancy Guiden, Chicago, Illinois, AMA Field Representative for Ohio.

**INTRODUCTION OF
OUT-OF-STATE PRESIDENTS
AND PRESIDENT-ELECT**

Dr. Irons introduced the following out-of-state presidents and one president elect: Dr. Frederick W. Bryant, Royal Oak, Michigan, President, Michigan State Medical Society and Ms. Alma Forti; Dr. Donald C. Barton, Corbin, Kentucky, President, Kentucky Medical Association, and Mrs. Barton; Dr. Gerald L. Andriole, Hazelton, Pennsylvania, President-Elect, Pennsylvania Medical Society and Mrs. Andriole; Dr. Cordell A. De La Pena, Clarksburg, West Virginia, President, West Virginia State Medical Association, and Dr. Erlinda De La Pena.

**INTRODUCTION OF
OSMA PAST PRESIDENTS**

Dr. Irons introduced the following Past Presidents of the Association: Dr. Charles L. Hudson, Cleveland; Dr. Oscar W. Clarke, Gallipolis; Dr. James L. Henry, Grove City; Dr. John J. Gaughan, Cleveland; Dr. Thomas W. Morgan, Gallipolis; Dr. Robert

G. Thomas, Elyria; Dr. Stewart B. Dunsker, Cincinnati; Dr. S. Baird Pfahl, Jr., Sandusky; Dr. A. Burton Payne, Ironton; Dr. Herman I. Abromowitz, Dayton; Dr. John E. Albers, Cincinnati.

INTRODUCTION OF PAST MEMBERS OF THE OSMA COUNCIL

Dr. Irons introduced former members of the Council in attendance: Dr. David A. Barr, Lima; Dr. Theodore J. Castele, Cleveland; Dr. William Dorner, Jr., Akron; Dr. D. James Hickson, Mt. Gilead; Dr. Stephen P. Hogg, Cincinnati; Dr. Edward G. Kilroy, Cleveland; Dr. W.J. Lewis, Dayton; and Dr. J. Hutchison Williams, Columbus.

MEMBERSHIP OUTREACH PROGRAM

Dr. Thomas R. Leech, Lima, Chairman of the OSMA Committee on Membership gave a report on OSMA membership. He reported that OSMA now has 20,628 members (including active, retired and student members). He announced the winners of the OSMA membership recruitment campaign: First place winner from Franklin County — Dr. Claire Wolfe; Second place winner from Stark County — Dr. Louis A. Kovaco; There was a tie for third place — Dr. George Ewing and Dr. David Spriggs (Stark County). Other winners were Dr. Maurice Mullett from Holmes County, Dr. Blake Selnick from Clermont County and Dr. Robert McDevitt from Hamilton County. One hundred percent (100%) membership was announced in the following counties: Carroll, Coshocton, Hancock, Monroe and Ottawa.

INTRODUCTION OF OSMA AUXILIARY PRESIDENT

Dr. Irons introduced Catherine

Staton, Springfield, President of the OSMA Auxiliary, who was escorted to the rostrum by Dr. William J. Marshall, Dayton. She was representing Mrs. Joyce Johnson, Columbus, Immediate Past President of the OSMA Auxiliary, who became hospitalized and was recuperating at the time of the House of Delegates meeting. Mrs. Staton expressed Mrs. Johnson's regret in not being able to attend and presented Dr. Irons with the first OSMAA honorary membership pin. Dr. Irons thanked Mrs. Staton for the honor.

PRESENTATION OF AMA-ERF CHECKS

Dr. Irons, assisted by Mrs. Staton, then presented AMA-ERF checks to the representatives of the following Ohio medical schools: Case Western Reserve University School of Medicine, Cleveland; University of Cincinnati College of Medicine, Cincinnati; Ohio State University College of Medicine, Columbus; Medical College of Ohio at Toledo; Northeastern Ohio Universities College of Medicine, Rootstown; Wright State University School of Medicine, Dayton. Contributions to Ohio's six medical schools from AMA-ERF totaled \$75,585.81.

PRESENTATION OF DISTINGUISHED SERVICE CITATION

Dr. Irons presented Dr. Oscar W. Clarke, Gallipolis with the OSMA Distinguished Service Citation award. Dr. and Mrs. Clarke were escorted to the rostrum by Dr. Thomas W. Morgan. The resolution, presented by OSMA Council, was read by Dr. Irons. It reads as follows:

WHEREAS, Oscar W. Clarke, MD, has served as a practicing internist at Holzer Clinic, Inc., in Gallipolis, Ohio for many years

and is currently serving as its President and Chairman of the Board of Directors; and

WHEREAS, Dr. Clarke served as a member of the Ohio State Medical Board from 1977-1984, and served as its President from 1982-1983; and

WHEREAS, He served on the Ohio State Medical Association Council from 1966-1972; and

WHEREAS, Dr. Clarke served faithfully and effectively as President of the Ohio State Medical Association from 1973-1974; and

WHEREAS, He served as a member of the Building Committee for OSMA's Headquarters Offices, which was dedicated May, 1974; and

WHEREAS, He has served as the Chairman of the Board of Directors of the Ohio Medical Education and Research Foundation (OMERF) since 1983; and

WHEREAS, He served as a member of the Ohio Delegation to the American Medical Association from 1970-1987; and

WHEREAS, Dr. Clarke served with distinction as Chairman of the Ohio Delegation to the AMA from 1978-1987; and

WHEREAS, Dr. Clarke served as a member of the AMA Medicolegal Committee from 1982-1987; and

WHEREAS, He was elected in December 1987 as a member of the prestigious and authoritative American Medical Association Council on Ethical and Judicial Affairs, which is charged with shaping national ethical and judicial guidelines for organized medicine; and

WHEREAS, Dr. Clarke has been dedicated to organized medicine for many years as a leader and statesman; and

WHEREAS, Dr. Clarke is also known as a "doctor's doctor";

therefore be it

RESOLVED, That the Ohio State Medical Association House of Delegates express its deepest respect and admiration for Dr. Clarke by conferring upon him the 1988 Ohio State Medical Association Distinguished Service Citation.

After a standing ovation from the House of Delegates, Dr. Clarke made a few brief remarks expressing his sincere thanks to the House for this honor.

PRESENTATION OF PLAQUES TO RETIRING MEMBERS OF THE COUNCIL

The following members of the Council received plaques in appreciation for their services to the Association as members of the Council: Dr. John E. Albers, Cincinnati; Dr. Thomas P. Price, Jr., Gallipolis; Dr. F.S. Bronn Rayne, Columbus; and Mr. Derrick D. Jeter, Dayton.

PRESENTATION OF PLAQUES TO RETIRING MEMBERS OF THE OHIO DELEGATION TO THE AMA

The following retiring members of the Ohio Delegation to the AMA received plaques in appreciation for their service: Dr. Oscar W. Clarke, Gallipolis, and Lt. Stephen W. Gilreath, Cincinnati (in absentia).

CERTIFICATES OF APPRECIATION

Dr. Irons then made announcement of the retiring members of Standing Committees and chairmen of Special Committees as follows: Dr. Charles C. Brausch, Cleveland, Chairman, Committee on Accreditation; Dr. John W. Vester, Cincinnati, Chairman, Committee on Education; Dr. S. Marcus Wigser, Cincinnati, Chairman, Committee on Judicial and Professional

Relations; Dr. William J. Marshall, Dayton, Chairman, Committee on Auditing and Appropriations; Dr. E. Huxley Miller, Cincinnati, Chairman, Task Force on AIDS; Dr. Roy L. Donnerberg, Columbus, Chairman, Committee on Geriatric Medicine; Dr. Kenneth A. Frederick, Cincinnati, Vice Chairman, Committee on Geriatric Medicine; Dr. John Peter Minton, Columbus, Chairman, Task Force on Cancer Screening; Dr. Charles G. Adams, Vermilion, Advisor to Medical Assistants; Dr. Thomas P. Price, Jr., Gallipolis, Member, Committee on Accreditation; Dr. Theodore J. Castele, Cleveland, Member, Committee on Communications; Dr. Jack L. Maffet, Carrollton, Member, Committee on Education; Dr. Robert J. Navarre, Jr., Toledo, Member, Committee on Education; Dr. Peggy-Jeanne St. Clair, Cleveland, Member, Committee on Judicial and Professional Relations; Dr. Donavin A. Baumgartner, Jr., Cleveland, Member, Committee on Membership; Derrick D. Jeter, Dayton, Student Member, Committee on Membership; Mrs. Barbara Marshall, Dayton, Member, Committee on Membership; Dr. Joseph Sudimack, Jr., Columbus, Member, Committee on Membership; Dr. Thomas R. Werner, Cincinnati, Member, Committee on Membership. Dr. Irons advised that they would receive their certificates of appreciation in the mail following the Annual Meeting.

MEDICAID REPORT

Dr. Janet K. Bixel, Columbus, then gave a Medicaid Drug Formulary report to the House.

REFERENCE COMMITTEE CHAIRMEN ANNOUNCED The following House of

Delegates Reference Committee Chairmen were announced by President Irons: Credentials of Delegates — Dr. Janet K. Bixel, Chairman, Franklin County; Tellers and Judges — Dr. J. Steven Polsley, Chairman, Champaign County; Resolutions Committee No. 1 — Dr. K. William Kitzmiller, Hamilton County; Resolutions Committee No. 2 — Dr. W. Paul Kilway, Jr., Summit County; Resolutions Committee No. 3 and President's Address — Dr. William H. Kose, Hancock County.

ELECTION OF COMMITTEE ON NOMINATIONS

The House of Delegates nominated and elected the following persons, pursuant to the OSMA Bylaws, one from each district, for the Committee on Nominations: First District — Edmund C. Casey, MD, Hamilton County; Second District — Jerry L. Hammon, MD, Miami County; Third District — Richard L. Faler, MD, Allen County; Fourth District — Richard J. Wiseley, MD, Lucas County; Fifth District — John J. Gaughan, MD, Cuyahoga County; Sixth District — Lloyd E. Slusher, MD, Mahoning County; Seventh District — F.V. Lavapies, MD, Belmont County; Eighth District — James R. Gaskell, MD, Athens County; Ninth District — Thomas P. Price, Jr., MD, Gallia County; Tenth District — Paul S. Metzger, MD, Franklin County; Eleventh District — Maurice E. Mullet, MD, Holmes County; Twelfth District — E. Gates Morgan, MD, Summit County.

Dr. Irons announced that under the system of rotation approved by the House of Delegates in 1963, the Chairman of the Committee this year would be the delegate from the Third District, Dr. Richard L. Faler, Allen County.

Dr. Irons then asked the House

to direct the Nominating Committee regarding election matters limiting the number of Alternate Delegates to be elected. The House approved the request.

PRESIDENT'S ADDRESS

Herbert E. Gillen, Executive Director, OSMA, introduced Dr. D. Ross Irons, who gave a presentation entitled "Taking Charge for a Change." After his speech, a short slide program prepared by the OSMA Department of Communications was presented. Dr. Irons announced that this slide presentation discussing the activities of the OSMA was available to any county medical society that wished to use it for meetings.

Dr. Irons received a standing ovation.

TWENTY-FIVE YEAR SERVICE AWARD PRESENTED

At this time Dr. Irons presented to Herbert E. Gillen, Executive Director of the OSMA, a plaque which read as follows:

WHEREAS, Herbert E. Gillen, Executive Director of the Ohio State Medical Association, has completed 25 years of service with the association; and

WHEREAS, He has served the OSMA with distinction and honor; and

WHEREAS, His dedication to Ohio physicians and their profession has made him a valued friend of medicine; and

WHEREAS, His leadership has propelled the Association into its role as one of the top medical associations in the country; therefore be it

RESOLVED, That the House of Delegates convey to Herb Gillen its highest levels of respect, admiration and affection; and be it further

RESOLVED, That this plaque

serve as a token of appreciation for his service and his achievements on behalf of the Ohio State Medical Association.

Jerry J. Campbell, Associate Executive Director, escorted Betsy (wife of Herb Gillen) to the rostrum for the presentation. The House of Delegates gave a standing ovation to Mr. Gillen for his dedicated 25 years of service.

MEMORIAL RESOLUTIONS INTRODUCED

The following Memorial Resolutions were presented to the House:

ROBERT A. LANG, PhD,
CLEVELAND

Read by Henry G. Krueger, MD
Fifth District Councilor

WHEREAS, Robert A. Lang, PhD, served as Executive Vice President of the Academy of Medicine of Cleveland from 1958-1985; and

WHEREAS, Dr. Robert A. Lang demonstrated a commitment of excellence to the community and the medical profession, providing education and instruction in the broad area of media communication and individual physician training; and

WHEREAS, Dr. Robert A. Lang, scholar, linguist, educator and administrator, provided a dedication of spirit and charm to the medical profession that was totally unique; and

WHEREAS, Dr. Robert A. Lang, a distinguished honorary member of the Academy of Medicine of Cleveland, died on February 16, 1988; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association, representing all physicians in Ohio, express their deepest sympathy to the family of Robert A. Lang, PhD, as well as their deep appreciation for his outstanding contributions to

medicine and society both in Ohio and nationally; and, be it further

RESOLVED, That a copy of this resolution be sent to the family of Robert A. Lang, PhD; and, be it further

RESOLVED, That the House of Delegates of the Ohio State Medical Association approve submitting a memorial resolution in honor of Robert A. Lang, PhD, for consideration at the 1988 Annual Meeting of the American Medical Association.

CHARLES S. NELSON,
COLUMBUS

Read by Hart F. Page, CAE
Executive Director Emeritus

WHEREAS, Charles S. Nelson joined the Ohio State Medical Association staff in 1928 and became Executive Secretary in 1935; and

WHEREAS, Mr. Nelson retired in December 1963, after 35 years of exemplary service; and

WHEREAS, As Executive Secretary of the Ohio State Medical Association his personal creed was Principle, Truth and Accuracy; and

WHEREAS, He never failed to remind the Association's officers of their responsibilities to the profession and the profession of its responsibilities to the public; and

WHEREAS, Mr. Nelson was acclaimed as one of the finest Executive Secretaries of his day; and

WHEREAS, He served as a Charter Member and President, from 1948-1949, of the Medical Societies Executives Association, which later became the Association of American Medical Society Executives; and

WHEREAS, Mr. Nelson died on March 25, 1988 at the age of 90; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association record its

admiration and appreciation for Charles Nelson's many contributions to organized medicine; and be it further

RESOLVED, That the Ohio State Medical Association convey its respect and sympathy to his wife Josephine, and to his family.

Dr. Irons then asked permission of the House for immediate action on the two memorial resolutions without referral and the resolutions were adopted by the House.

INTRODUCTION OF RESOLUTIONS

Dr. Irons announced that since the resolutions had been printed and distributed to the members of the House prior to the meeting and the assignment of resolutions to the Resolutions Committee had

also been presented to the House in writing, individual introduction of the resolutions would be waived unless there were objections voiced by the House. There were none and the reading of the resolutions was waived.

COMMITTEE ON EMERGENCY RESOLUTIONS REPORT

Dr. Irons announced that five (5) Emergency Resolutions were submitted to the Committee on Emergency Resolutions. Of the five, four were accepted as timely. Resolution No. 2, Nursing Shortage — Implementation of American Medical Association Board of Trustees Report CC I-88 and No. 3, Registered Care Technologists, were sent to Reference Committee No. 3, and

Emergency Resolution No. 4, Physician Peer Review Antitrust Protection, and No. 5, Peer Review, were sent to Reference Committee No. 2.

ACTION REPORT ON 1987 RESOLUTIONS

Dr. Irons announced that a report on the "follow-up" work on 1987 Resolutions was given to all Delegates and Alternate Delegates in their handbook — Action Report on 1987 Resolutions.

HOUSE RECESSED

The House then recessed until the final session, 1:00 p.m. Sunday, May 22, 1988.

AIM HIGH

READY FOR A CHANGE OF PACE?

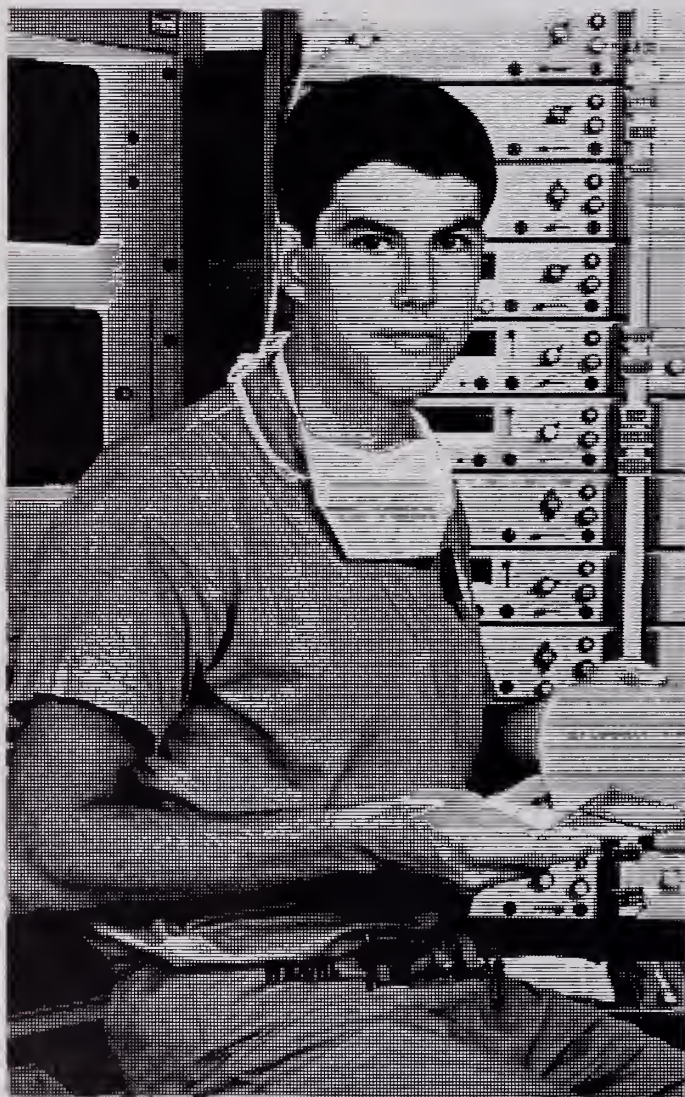


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MINUTES OF THE FINAL SESSION OSMA HOUSE OF DELEGATES

The final session of the House of Delegates was convened at 1:10 p.m. on Sunday, May 22, 1988. Dr. Irons called the meeting to order.

PRESENTATION OF GREENE COUNTY MEDICAL SOCIETY RESOLUTION

Dr. Irons called Dr. Shamin A. Shamsi, Greene County Delegate, to the rostrum to present a plaque to the Greene County Medical Society for its Centennial Commemoration. The resolution honoring 100 years of service to the Greene County Community and the state of Ohio was read by Dr. Irons. It read as follows:

WHEREAS, the physicians of the Greene County Medical Society have been serving the health-care needs of the citizens of Greene County since the society was founded in 1888; and

WHEREAS, the physicians of the Greene County Medical Society have made immeasurable contributions to the well-being of citizens throughout Ohio through active participation in organized medicine and the OSMA House of Delegates; and

WHEREAS, the Greene County Medical Society has improved the health of the citizens of Greene County by offering such public assistance programs as a physician referral service, a physicians' speakers bureau, media relations, peer review and public education; and

WHEREAS, this year the Greene County Medical Society is celebrating its centennial with activities which will commemorate the organization's 100 years of service and inform the public of contributions the society's members and medicine have made in the community since 1888; therefore be it

RESOLVED, that the Ohio State Medical Association joins in celebrating the centennial of the Greene County Medical Society, and recognizes the contributions its past and present members have made to the quality medical care of the citizens of Greene County and the state of Ohio.

INTRODUCTION OF HONORED GUEST

Dr. Irons then introduced Dr. John MacDougall, Indianapolis, President of the Indiana State Medical Association.

REPORT OF THE CREDENTIALS COMMITTEE

Dr. Janet K. Bixel, Franklin County, Chairman of the Credentials Committee, reported that out of 256 delegates eligible to vote, 225 were present, credentialed and seated.

ELECTION OF PRESIDENT-ELECT

Dr. Irons called for nominations for the office of President-Elect. Dr. Herman I. Abromowitz, Dayton, placed in nomination

William J. Marshall, MD, Dayton, Councilor of the Second District. The nomination was seconded by Oscar W. Clarke, MD, Gallipolis. Dr. William H. Kose, Hancock County, placed in nomination Dr. Thomas R. Leech, Lima, Third District Councilor. The nomination was seconded by Lee J. Vesper, MD, Cincinnati. There were no other nominations and a written ballot was ordered. Dr. William J. Marshall was elected President-Elect. Dr. Leech congratulated Dr. Marshall and thanked those who supported his candidacy. Dr. Marshall expressed his thanks to the House and was seated at the head table.

REPORT OF THE NOMINATING COMMITTEE

Dr. Richard L. Faler, Delegate, Allen County, Chairman of the Nominating Committee, was called to the podium. The report of the Nominating Committee was presented to the House. The House approved the recommended candidates by acclamation. Those individuals were elected as follows:

For Secretary-Treasurer for a three-year term commencing May 23, 1988, Joseph Sudimack, Jr., MD, Columbus.

For Councilors from the odd-numbered districts for a two-year term commencing May 23, 1988,

FIRST DISTRICT: Stanley J. Lucas, MD, Cincinnati; **THIRD DISTRICT:** William H. Kose, MD, Findlay; **FIFTH DISTRICT:**

Henry G. Krueger, MD, North Olmsted; **SEVENTH DISTRICT:** Nermin D. Lavapies, MD, Martins Ferry; **NINTH DISTRICT:** Richard Villarreal, MD, Wheelersburg; **ELEVENTH DISTRICT:** Charles G. Adams, MD, Vermilion.

For Councilor for a term commencing May 23, 1988 and ending May 8, 1989, **SECOND DISTRICT:** Walter A. Reiling, Jr., MD, Dayton.

For Delegate to the American Medical Association to serve a term commencing May 22, 1988 and ending December 31, 1989, Donavin A. Baumgartner, Jr., MD, Cleveland.

For Delegate to the American Medical Association to serve a term commencing January 1, 1989 and ending December 31, 1990, Herman I. Abromowitz, MD, Dayton; Theodore J. Castele, MD, Cleveland; Roland A. Gandy, Jr., MD, Toledo; Jerry L. Hammon, MD, Dayton; Stanley J. Lucas, MD, Cincinnati; Thomas W. Morgan, MD, Gallipolis; Richard J. Nowak, MD, Cleveland; H. William Porterfield, MD, Columbus; and S. Baird Pfahl, MD, Sandusky.

Mrs. Audrey Ludwig, Cincinnati, was elected by the OSMA Medical Student Section as an Alternate Delegate for one year commencing February 27, 1988, in accordance with Chapter 5, Section 7 of the OSMA Bylaws.

For Alternate Delegate to the American Medical Association to serve a term commencing January 1, 1989 and ending December 31, 1990, Edmund C. Casey, MD, Cincinnati; Jerome Kimmelman, MD, Toledo; Henry G. Krueger, MD, North Olmsted; William J. Marshall, MD, Dayton; Raymond J. McMahon, Jr., MD, Massillon; Walter A. Reiling, Jr., MD, Dayton; and Lee J. Vesper, MD, Cincinnati.

Dr. Thomas E. Fox, Warren County, was recognized by the House for his 30 years of service

to the OSMA House of Delegates.

Dr. Baird Pfahl, Erie County, introduced Robert L. Dion, the new CEO of PICO, to the House of Delegates.

REPORT OF RESOLUTIONS COMMITTEE NO. 1

Dr. K. William Kitzmiller, MD, Hamilton County, Chairman, presented the report of Resolutions Committee No. 1. The House took action on the report as follows:

RESOLUTION NO. 01-88

Requiring a Completed Ballot

RESOLVED, That the Bylaws of the Ohio State Medical Association be amended as follows:

Chapter 5. Nomination and Election of Officers
Section 7. Election of Officers and Delegates and Alternate Delegates of the American Medical Association

Paragraph 3. Add the following at the end of the paragraph:

No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one vote for any nominee. (For example: If upon any ballot the number of positions to be filled is four (4), then each delegate voting must vote for (4) of the nominees for such positions.)

By official action, the House voted to adopt Resolution No. 01-88.

RESOLUTION NO. 02-88

Single Shot Voting

By official action, the House voted to reject Resolution No. 02-88.

AMENDED RESOLUTION NO. 03-88

Dues Increase

RESOLVED, That the annual dues of the Ohio State Medical Association be increased from \$295 to \$395 effective with 1989 dues.

By official action, the House voted to adopt Amended Resolution 03-88.

RESOLUTION NO. 04-88

Spouse Active Membership

RESOLVED, That the Ohio State Medical Association Council, in an effort to recruit more physician/physician couples, each with separate membership, recommends that a new category of membership be created to allow for dual membership by spouses with a reduced dues structure for the couple; and, be it further

RESOLVED, That the Constitution and Bylaws of the OSMA be amended as follows:

CONSTITUTION

ARTICLE III — Section I

1. Active Members/**SPOUSE ACTIVE MEMBERS** including retired active members)

BYLAWS

Chapter 1.

Section 2. Classification of Membership

(a) Active members/**SPOUSE ACTIVE MEMBERS**. Active members of this Association shall comprise all the active members **AND SPOUSE ACTIVE MEMBERS** in good standing of the several component societies. Active members **AND SPOUSE ACTIVE MEMBERS** shall have the right to vote and hold office.
Chapter 2.

Section 1. Determination of Dues. The annual dues and assessments of Active Members and Associate Members of this Association shall be determined by the House of Delegates and shall be levied per capita on such members. **A MEMBER WHO IS THE SPOUSE OF AN ACTIVE MEMBER IS ELIGIBLE FOR A REDUCTION FROM THE PER CAPITA DUES AND ASSESSMENTS DETERMINED BY THE HOUSE OF DELEGATES. THE COUNCIL**

OF THIS ASSOCIATION SHALL HAVE THE AUTHORITY PROMULGATE THE AMOUNT OF DUES AND ASSESSMENTS FOR AN ACTIVE MEMBER'S SPOUSE. They shall be payable before January 1, of the calendar year for which such dues are levied. The dues and assessments shall be collected by the designated officer of each component society and shall be forwarded to the headquarters of this Association, together with such data as shall be required by this Association for its own record of such society's officers and membership.

By official action, the House referred Resolution No. 04-88 to the OSMA Council.

RESOLUTION NO. 05-88

Reduction of Dues for Physicians in Their Second Year of Practice

RESOLVED, That the OSMA dues for Active Members and Associate Members be reduced by 25% for physicians in their second year of practice after training is completed • **ON REQUEST FOR REDUCTION OF DUES.**

By official action, the House voted to amend Resolution No. 05-88, as indicated in capital letters with deletion as noted, and to adopt it as amended.

RESOLUTION NO. 06-88

Dues Reduction for Physicians Over 65 With Reduced Practices

RESOLVED, That the Ohio State Medical Association offer a 50% reduction in dues to those physicians over the age of 65 who have reduced their practices and request a reduction in dues.

By official action, the House voted to adopt Resolution No. 06-88.

AMENDED RESOLUTION NO. 07-88

Publication Charge to Retired and Disabled-Exempt Members
RESOLVED, THAT OSMA POLL ITS RETIRED MEMBERS

AS SOON AS POSSIBLE TO DETERMINE HOW MANY WISH TO REMAIN ON OSMA'S ACTIVE MAILING LIST; AND IF THE NUMBER DESIRING TO BE ON THE ACTIVE MAILING LIST WOULD PUT OSMA'S SECOND CLASS POSTAGE PRIVILEGE IN JEOPARDY; and, be it further

RESOLVED, That the OSMA charge a publication fee of \$40 **\$10 PUBLICATION FEE, EFFECTIVE IN 1988**, to retired members ~~effective in 1988~~, **WHO WISH TO REMAIN ON THE ACTIVE MAILING LIST; and be it further**

RESOLVED, That the ~~exempt~~ **RETIRED** member retain his membership if the physician chooses not to receive the publications by paying the \$40 **\$10** charge.

By official action, the House voted to amend Amended Resolution No. 07-88 as indicated in capital letters with deletions as noted, and to adopt it as amended.

RESOLUTION NO. 08-88

Resolutions by

Hospital Medical Staff

RESOLVED, That the Bylaws of the Ohio State Medical Association be amended as follows:

Section 11. Resolutions.

Except as otherwise provided under Section 12, every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. Each resolution which, if adopted, would require expenditure of funds by the Association, shall have

attached, a statement of the amount of the estimated annual expenditure. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived under Section 12, or by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates.

The Executive Director shall cause to be published in the Journal in advance of such meeting of the House of Delegates such resolutions as the President or the Council may designate.

No consideration may be given, or any action taken, by the Committee on Resolutions or by the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates; provided, however, that a resolution dealing with an event or development occurring too late to permit the introduction of any such resolution at the opening session may be introduced at a later session with the consent of at least four-fifths (4/5) of the delegates present; and upon its introduction, such resolution shall be referred to the

Committee on Resolutions for consideration and report; and, provided further, that the Committee on Resolutions shall have the right to amend any resolution presented or introduced, or to draft a composite or substitute resolution embracing the same subject matter as that contained in a resolution or resolutions presented or introduced, and to submit such amended, composite or substitute resolution for adoption by the House of Delegates, and the House of Delegates shall have the right to adopt any such amended, composite or substitute resolution.

Any resolution adopted by the House of Delegates in 1979 and thereafter will become null, void and of no effect if not repropounded and readopted within four years from the effective date of the adoption of the resolution. Within the fourth year of their effective date, the House of Delegates will be notified by January 31 in writing of those resolutions subject to readoption at the Annual Meeting at which they will be considered.

Section 12 — Hospital Medical Staff Section Resolutions — A maximum of five resolutions, directly related to issues of concern to physicians on Hospital Medical Staffs and matters of immediate importance, adopted by and presented from the business meeting of the hospital medical staff section representative assembly, as provided in their bylaws, may be presented for consideration by the house of delegates at any time before the opening of the House of Delegates. All other resolutions adopted by and presented from the business meeting of the Representative Assembly of the Hospital Medical Staff Section shall be submitted in report form to the House of Delegates at the following-year's annual meeting **ANNUAL MEETING** of the

House of Delegates for purpose of filing.

All other sections of the Bylaws should be renumbered accordingly.

By official action, **the House voted to amend Resolution No. 08-88, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

RESOLUTION NO. 09-88

Hospital Medical Staff Section Councilor

RESOLVED, That the Constitution and Bylaws of the Ohio State Medical Association be amended as follows:

CONSTITUTION OF THE OHIO STATE MEDICAL ASSOCIATION

ARTICLE VII

THE COUNCIL

The Council shall consist of one councilor from each councilor district, one non-voting member from the Hospital Medical Staff Section, one non-voting councilor from the Resident Physician's Section, one non-voting student member from the Medical Student Section and the other elected officers of this Association. The Council shall be the executive body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates.

BYLAWS OF THE OHIO STATE MEDICAL ASSOCIATION

CHAPTER 7 — SECTION 4

Section 4. Individual Duties of Councilors. Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in his district and of keeping in touch with the activities of each of such

societies. In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics. The duties of the non-voting councilor from the Hospital Medical Staff Section shall be set forth in the Bylaws of said section. The duties of the non-voting councilor from the Medical Student Section shall be set forth in the Bylaws of said section. The duties of the Councilor from the Resident Physician's Section shall be set forth in the Bylaws of said section which shall be approved by the Council.

By official action, **the House voted to adopt Resolution No. 09-88.**

RESOLUTION NO. 10-88

Safeguard Confidentiality of PRO Records

RESOLVED, That the Ohio State Medical Association ask Peer Review Systems, Inc. to reassess its decision allowing physician reviewers the option of removing from the PRO premises, patient records for the purpose of off-site review.

By consent, **the House adopted Resolution No. 10-88.**

RESOLUTION NO. 11-88

Health Insurance Company Evaluation

By consent, **the House rejected Resolution No. 11-88.**

RESOLUTION NO. 12-88

Third-Party Physician Payment Notification

RESOLVED, That the Ohio State Medical Association work with insurance companies to better coordinate patient notification and actual physician payment dates.

By consent, **the House adopted**

Resolution No. 12-88.

RESOLUTION NO. 13-88

Medicare, Medical Necessity

RESOLVED, That the House of Delegates of the Ohio State Medical Association request OSMA Headquarters to ask Nationwide to cease and desist sending such improper letters.

By official action, the House referred Resolution No. 13-88 to the OSMA Council.

RESOLUTION NO. 14-88

Medically Unnecessary Services Letter

RESOLVED, That the Lake County Medical Society unanimously opposes the oppressive legislative action to impose medical necessity guidelines on physicians. These guidelines are only consistent with delivering poor quality care to patients and exposing the medical profession to potentially grave liabilities which can only accelerate medical costs to the taxpayers.

By official action, the House referred Resolution No. 14-88 to the OSMA Council.

RESOLUTION NO. 15-88

Medically Unnecessary Services

RESOLVED, That the Ohio State Medical Association take appropriate action to assure that letters from Nationwide Mutual Insurance Company, as the Medicare Part B carrier, sent to physicians regarding alleged "medically unnecessary services" include the patient's name, the date of the service(s) determined to be "medically unnecessary"; the cost of the service(s) in question; and the criteria used by the carrier in making the determination; and, be it further

RESOLVED, That the Ohio State Medical Association and the American Medical Association take appropriate action to require that Medicare Part B carriers refrain from informing Medicare covered

patients that services provided by a physician are "medically unnecessary" until such time as the physician has an opportunity to have the determination reviewed and if appropriate to have the results of a formal hearing; and, be it further

RESOLVED, That the Ohio State Medical Association urge the American Medical Association to take appropriate legal action to require that Medicare Part B carriers provide physicians with adequate information in all correspondence regarding alleged medically unnecessary services and further that the AMA take appropriate legal action in an effort to halt the practice by Part B carriers of notifying Medicare-covered patients regarding alleged medically unnecessary services until such time as the review and hearing process has been completed; and, be it further

RESOLVED, That the Ohio State Medical Association House of Delegates urge the House of Delegates of the American Medical Association to take appropriate legislative action to rescind the Medicare medically unnecessary services program.

By official action, the House referred Resolution No. 15-88 to the OSMA Council.

AMENDED RESOLUTION

NO. 16-88

A Monthly Medicare Newsletter

RESOLVED, That a concise, monthly Medicare newsletter or fact sheet be incorporated into the *OSMAgram* in a manner that will readily identify for physician readership Medicare issues on a timely basis, if needed.

By official action, the House voted to adopt Amended Resolution No. 16-88.

RESOLUTION NO. 17-88

Withholding of Political Contributions

By consent, the House rejected

Resolution No. 17-88.

AMENDED RESOLUTION

NO. 18-88

Voluntary Acceptance of Medicare Assignment Through

Modifications of Project OPEN

RESOLVED, That Ohio Project Elderly Needy (Project OPEN) Category II be continued in its present format; and, be it further

RESOLVED, That Project OPEN Category I qualifying annual income be reviewed and determined by council; and be it further

RESOLVED, That the Ohio State Medical Association promote a modified Project OPEN statewide as a voluntary alternative to mandatory Medicare assignment.

By official action, the House voted to adopt Amended Resolution No. 18-88.

RESOLUTION NO. 19-88

Independent Study of Mandatory Medicare Assignment in the State of Ohio

By consent, the House rejected Resolution No. 19-88.

SUBSTITUTE RESOLUTION

NO. 20-88

Concurrent Care

RESOLVED, That the Ohio State Medical Association urge the American Medical Association to recommend immediate action by the Health Care Financing Administration and Congress to revise its present policy on concurrent care so as not to adversely affect quality of patient care; and, be it further

RESOLVED, That the judgment of the attending physician not be curtailed by present limitations of covered benefits for hospitalized patients, especially when physician consultants are needed to maintain the highest standard of care; and, be it further

RESOLVED, That the Ohio State Medical Association request

the American Medical Association House of Delegates to communicate with all members of Congress the impact of these Medicare rules in limiting the quality of services and care to the hospitalized Medicare patient; and, be it further

RESOLVED, That the AMA work with HCFA to develop a less cumbersome mechanism that would more identify all physicians who are providing the highest quality of active "concurrent care" for patients; and, be it further

RESOLVED, That this resolution be forwarded to the AMA for consideration by its House of Delegates at its A-88 meeting.

By official action, the House voted to adopt Substitute Resolution No. 20-88 and referred it to Council for immediate implementation.

**RESOLUTION NO. 21-88
Employees Right to Choice of
Health Insurance Option**

RESOLVED, That the Ohio State Medical Association vigorously pursue legislation that would make it mandatory that employers that offer health insurance programs for their employees must offer an option of health insurance where employees have full choice of physicians and health care facilities; and, be it further

RESOLVED, That a similar resolution be introduced in the House of Delegates of the American Medical Association.

By consent, the House adopted Resolution No. 21-88.

**RESOLUTION NO. 22-88
Licensure of Medical Care
Review Agencies**

RESOLVED, That any insurer, third-party payor, or medical care review agency who requires prior approval of medical care be licensed by the Ohio State Medical Board, have a place of business in

the state of Ohio, and be directed by an Ohio licensed physician; and, be it further

RESOLVED, That the Legislative Committee of the Ohio State Medical Association prepare and promote such legislation.

By official action, the House referred Resolution No. 22-88 to the OSMA Council.

**RESOLUTION NO. 23-88
Maintain Physician Authority in
Determining Medical Necessity**

RESOLVED, That the Ohio State Medical Association and the American Medical Association consider it unethical for members to participate in any voluntary program in which medical necessity for treatment is determined by someone other than the treating physician(s); and, be it further

RESOLVED, That this concept be referred to the American Medical Association at the 1988 Annual Meeting.

By official action, the House referred Resolution No. 23-88 to the OSMA Council.

**RESOLUTION NO. 24-88
Class Action Suit Against
Medicare Carrier**

RESOLVED, That the Ohio State Medical Association, through its legal arm, file a class-action suit against Nationwide Insurance Company on behalf of all non-participating Ohio physicians enjoining Nationwide Insurance Company to desist from this behavior and suing the defendant for costs sustained in this action as well as punitive damages, so that an escrow account may be set up to aid physicians who have been damaged by Nationwide Insurance Company's unwarranted behavior.

By official action, the House referred Resolution No. 24-88 to the OSMA Council.

**RESOLUTION NO. 25-88
Federal PRO**

RESOLVED, That the House of Delegates of the Ohio State Medical Association request members of the Ohio Congressional Delegation to introduce a bill for repeal of Federal PRO.

The House voted that Resolution No. 25-88 be taken off the Consent Calendar, then adopted it.

**RESOLUTION NO. 26-88
Third-Party Payor
Responsibility Act**

RESOLVED, That the Ohio State Medical Association seek enactment of legislation by the Ohio General Assembly to impose liability and financial responsibility for injuries to patients consequent to review decisions by third-party payors patterned after AMA model legislation entitled "Third-Party Payor Responsibility Act."

The House voted that Resolution No. 26-88 be taken off the Consent Calendar, then adopted it.

**RESOLUTION NO. 27-88
Uncompensated Service to
Third-Party Payors**

By consent, the House rejected Resolution No. 27-88.

THE REPORT OF
RESOLUTIONS COMMITTEE
NO. 1, AS A WHOLE, AS
AMENDED, WAS APPROVED
BY THE HOUSE.

Dr. Irons called for the report of Resolutions Committee No. 2.

**REPORT OF RESOLUTIONS
COMMITTEE NO. 2**

Dr. W. Paul Kilway, MD, Summit County, Chairman, presented the report of Resolutions Committee No. 2. The House took action on the report as follows:

**RESOLUTION NO. 28-88
Resolution of Commendation:
Oscar W. Clarke, MD**

WHEREAS, Oscar W. Clarke, MD, has faithfully served the Ohio State Medical Association as Alternate Delegate and later

Delegate to the American Medical Association House of Delegates continuously since 1970; and

WHEREAS, Dr. Clarke has effectively and capably served as Chairman of the Delegation from 1978 until his election to the AMA Council on Ethical and Judicial Affairs on December 6, 1987; and

WHEREAS, Dr. Clarke has provided insightful and creative leadership at the state level, serving as OSMA President from 1982 to 1983, member of the Ohio State Board of Medical Examiners from 1977 to 1984, as well as many other positions, both elected and appointed, including service in his Gallia County Medical Society; and

WHEREAS, Dr. Clarke has long been a strong supporter of medical students and their participation in organized medicine in the state of Ohio; and

WHEREAS, Most importantly, Dr. Clarke has consistently been a patient advocate, embodying most keenly the true meaning of being a physician; therefore be it

RESOLVED, That the OSMA-MSS and OSMA House of Delegates express its sincere and heartfelt gratitude to Oscar W. Clarke, MD, for his years of selfless service to this Association as Chairman of the Ohio Delegation to the American Medical Association and congratulate him on his election to the AMA Council on Ethical and Judicial Affairs; and, be it further

RESOLVED, That the Ohio State Medical Association record this resolution of commendation as a part of the official minutes of the 1988 Annual Meeting of the Ohio State Medical Association House of Delegates; and, be it further

RESOLVED, That a copy of this resolution of commendation be provided to Oscar W. Clarke, MD, and his wife Susan.

By consent, **the House adopted Resolution No. 28-88.**

SUBSTITUTE RESOLUTION NO. 29-88

Limitation on Resident Work Hours (Replacing No. 29 & 30)

RESOLVED, That the Ohio State Medical Association adopt the principles and recommendations of Amended Report C of the American Medical Association Council on Medical Education as adopted at AMA Interim 87; and, be it further

RESOLVED, That the Ohio State Medical Association await further information from the AMA/ACGME concerning resident work hours prior to developing any proposals by the OSMA.

By official action, **the House voted to adopt Substitute Resolution No. 29-88.**

AMENDED RESOLUTION NO. 31-88

Parental and Sick Leave Policies in Residency Programs

RESOLVED, That the Ohio State Medical Association express its support for clearly stated parental and sick leave policies in all accredited residency programs in order to facilitate informed decision-making by applicants to those programs; and, be it further

RESOLVED, That the Ohio State Medical Association recommend to the American Medical Association that parental and sick leave policies be added to residency program information available on the computer information network currently under development by the AMA.

By official action, **the House voted to adopt Amended Resolution No. 31-88.**

AMENDED RESOLUTION NO. 32-88

Young Physicians as Delegates and Alternate Delegates

RESOLVED, That the OSMA urge each of its county medical societies to encourage and select qualified young physicians to serve

as delegates or alternate delegates to the OSMA as a means of getting these physicians more actively involved in the process which will affect their future and the future of all physicians.

By official action, **the House voted to adopt Amended Resolution No. 32-88.**

SUBSTITUTE RESOLUTION No. 33-88

Living Wills and Durable Power of Attorney for Health Care in the State of Ohio (Replacing No. 33, 34, 48, 49 & 50)

RESOLVED, That the OSMA actively assist Ohio legislators as they consider legislation recognizing living wills and/or the durable power of attorney for health care in the state of Ohio; and be it further

RESOLVED, That ~~this legislation should include as a minimum~~ **OSMA SUPPORT LEGISLATION THAT, AS A MINIMUM, WOULD:**

- (A) identify the rights and responsibilities of adults who wish to make a living will or designate a durable power of attorney for health care; and
- (B) establish immunity from civil and criminal prosecution for physicians who, in compliance with a living will or the instructions of a durable power of attorney for health care, withhold treatment from the patient; and
- (C) recognize that some physicians are ethically constrained from complying with the instructions contained in a living will or delivered by a durable power of attorney for health care; and
- (D) establish immunity from civil and criminal prosecution for those physicians who refuse to comply with a living will or the instructions of a durable power of attorney for health care, and provide that these

physicians shall not interfere with the timely transfer of patient care to another physician.

By official action, the House voted to amend Substitute Resolution No. 33-88, as indicated in capital letters with deletions as noted, and to adopt it as amended.

RESOLUTION NO. 35-88
Oppose Voluntary Active Euthanasia (Mercy Killing)

RESOLVED, That the Ohio State Medical Association adopt a policy statement "Voluntary Active Euthanasia (mercy killing) is unethical" to coincide with current AMA stated policy; and, be it further

RESOLVED, That the Ohio State Medical Association actively oppose the enactment of any legislation which would legalize voluntary active euthanasia (mercy killing) and/or legislation requiring a physician to directly or indirectly participate in such action(s).

By official action, the House voted to adopt Resolution No. 35-88.

AMENDED RESOLUTION
No. 36-88

Health Insurance for New or Improved Modalities

RESOLVED, That the Ohio State Medical Association encourage the American Medical Association to develop and present to insurance companies a summary statement of the value of proved and improved modalities for screening, diagnosing or treating disease and urge those companies to provide insurance coverage for the use of such modalities for the benefit of their insured, our patients; and, be it further

RESOLVED, That the OSMA encourage the AMA to request all specialty societies to provide the AMA with information about new or improved modalities that should be included in this summary

statement including sufficient background material to assist the AMA in preparing their statement; and, be it further

RESOLVED, That the OSMA Council report to the 1989 House of Delegates the results of its efforts regarding this resolution.

By official action, the House voted to adopt Amended Resolution No. 36-88.

AMENDED RESOLUTION
NO. 37-88

Infertility Insurance Coverage

RESOLVED, That the Ohio State Medical Association encourage third-party payor health insurance carriers to provide insurance benefits for the diagnosis and treatment of recognized male and female infertility; and, be it further

RESOLVED, That this resolution be forwarded to the American Medical Association for consideration and action by the House of Delegates.

By official action, the House voted to adopt Amended Resolution No. 37-88.

AMENDED RESOLUTION
NO. 38-88

Organ Harvesting from Nonviable Fetuses

RESOLVED, That the Ohio State Medical Association ask the American Medical Association to establish ethical guidelines which address the use of prenatal diagnoses results and organ harvesting.

By official action, the House voted to adopt Amended Resolution No. 38-88.

SUBSTITUTE RESOLUTION
NO. 39-88

Hospital Advertising
(Replacing No. 39 & 40)

RESOLVED, That the Ohio State Medical Association inform the Ohio Hospital Association of its concern regarding the hospital advertising issue; and, be it further

RESOLVED, That the OSMA ask the OHA to inform its constituent hospitals of physicians' concerns regarding hospital advertising including its impact on patient care; and, be it further

RESOLVED, That the OSMA encourage each individual member to discuss their concerns regarding this issue with their hospital administration.

By official action, the House referred Substitute Resolution No. 39-88 to the OSMA Council.

RESOLUTION NO. 41-88
Reporting Physician's Restriction of Privileges

By consent, the House rejected Resolution No. 41-88.

AMENDED RESOLUTION
NO. 42-88

Association Liability Insurance

RESOLVED, That the Ohio State Medical Association investigate a group association liability policy for component societies of OSMA and report to the OSMA Council by January, 1989 and to the 1989 OSMA House of Delegates.

By official action, the House voted to adopt Amended Resolution No. 42-88.

RESOLUTION NO. 43-88
Protection of Pension and Profit-Sharing Funds

RESOLVED, That the Ohio State Medical Association legislative department assist a legislator or legislators to propose a bill exempting pension and profit sharing funds from seizure in malpractice judgments.

By consent, the House adopted Resolution No. 43-88.

SUBSTITUTE RESOLUTION
NO. 44-88

Awareness of Participating Providers
(Replacing No. 44-88)

RESOLVED, That all marketing of HMOs, PPOs and other

alternate health care delivery systems clearly state to prospective participants that joining the program may terminate their prior doctor-patient relationship.

By official action, the House voted to adopt Substitute Resolution No. 44-88.

RESOLUTION NO. 45-88

AMA Lobbying

The House voted that Resolution No. 45-88 be taken off the Consent Calendar, discussed it, then rejected the resolution.

RESOLUTION NO. 46-88

Statute of Limitations

Resolution No. 46-88 was withdrawn by the sponsor.

AMENDED RESOLUTION NO. 47-88

Cooperation in Medical Care

RESOLVED, That the Ohio State Medical Association make all effort through its Hospital Medical Staff Section to align the medical staff, hospital administration and nursing staff into a cooperative coalition to provide the best care for the patient.

By official action, the House voted to adopt Amended Resolution No. 47-88.

RESOLUTION NO. 51-88

Standardized Definition of Emergency

RESOLVED, That the Ohio State Medical Association requests the American Medical Association to develop a standardized definition of a "bona fide emergency" in cooperation with groups such as ACEP and others to be utilized as a nationally recognized standard for physicians, third-party payor plans of all types and patients.

By consent, the House adopted Resolution No. 51-88.

AMENDED REPORT A — 1988

Committee to Review OSMA House of Delegates Policy

POLICIES TO BE RETAINED — 1984 HOUSE OF DELEGATES PROCEEDINGS

Special Session,

April 14, 1984 PRO

3-84 Dues Increase

8-84 Hospice Care Regulations

9-84 Medical Care for the Elderly

10-84 DRGs

13-84 Third-Party Reimbursement Problems

16-84 Cognitive Services Reimbursement

21-84 Payment for Physicians' Services

26-84 CPT-4 Codes for Complex Services

32-84 Report on Resolutions From Prior Years

36-84 Physician Criticism of Colleagues

37-84 Hospital Ethics Committee

38-84 Free Choice of Physician

43-84 Financial Support — Homeless and Chronically Mentally Ill

46-84 Mandatory Use of Protective Helmets for Motorcyclists

49-84 Preference for Hospital Delivery Over Home Births

50-84 Supervision of Physicians Assistants

55-84 ACLS and ATLS Courses for Physicians

POLICIES NOT TO BE RETAINED — 1929 THROUGH 1983

1959 Universal Immunizations

20-69 Reimbursement as it Relates to Health Planning Agencies

44-72 Regional Medical Programs

2-75 Professional Liability Commission

1-76 Parliamentary

30-77 Liability-Reform (RETAINED)

75-77 Recommended Alternations of Hospital Discharge Summaries

19-78 MSMS vs. BC/BS

21-78 Accountability

24-78 Collateral-Source (RETAINED)

25-78 Tort-Reform (RETAINED)

28-78 Amendments to H.B. 682

45-78 Community Mental Health Centers

58-78 Ohio Department of Public Welfare (Medicaid Division) Preadmission Review Forms

5-79 Insurance Coverage for Ambulatory Surgery

44-79 National Health Planning and Resources Development Act of 1974

47-79 Use of Social Security Numbers as Universal Identifiers

7-80 Mandatory Continuing Medical Education

49-80 Regionalization of Medical Services

12-81 Ohio State Medical Association Annual Meeting

15-81 Women in Medicine

23-81 Reconvene Task Force on Professional Liability

47-81 Manpower

50-81 "PAP Smear" Law

60-81 Hospital Malpractice Insurance

10-82 Establishment of a Resident Physician's Committee Within the OSMA

13-82 Mandatory CME

23-82 Health Planning Advisory Panels

31-82 Strengthening of Ohio's Drunk Driving Laws

17-83 Control of Look-Alike Drugs and Over-the-Counter Drug Abuse

20-83 Handicapped Children

21-83 Problems of Senior Citizens

38-83 Contraceptive Devices for Minors

By official action, the House voted to adopt Amended Report A.

AMENDED EMERGENCY RESOLUTION NO. 04-88

Physician Peer Review Antitrust Protection

RESOLVED, That the Ohio State Medical Association House of Delegates authorizes the Council to review PEER REVIEW SYSTEMS IN REGARDS TO the

Patrick vs. Burget decision, and if appropriate, recommend introduction of legislation to ensure Ohio physicians will **HAVE** ~~obtain maximum benefit from the~~ antitrust immunities established in the Health Care Quality Improvement Act of 1986 at the earliest possible time.

~~RESOLVED, that the OSMA inform its members concerning the implications of and the potential liability risk associated with peer review activity subsequent to the *Patrick v. Burget* decision.~~

REASSURE ITS MEMBERS THAT PEER REVIEW ACTIVITY REMAINS VIABLE, BUT THAT POTENTIAL LIABILITY RISK EXISTS UNLESS FAIR IMPARTIAL PEER REVIEW IS PERFORMED.

By official action, the House voted to amend Amended Emergency Resolution No. 04-88, as indicated in capital letters with deletions as noted, and to adopt it as amended.

**EMERGENCY RESOLUTION
NO. 05-88**

Peer Review

By official action, the House rejected Emergency Resolution No. 05-88.

THE REPORT OF RESOLUTIONS COMMITTEE NO. 2, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Dr. Irons yielded the chair to Dr. Baumgartner who called for the report of Resolutions Committee No. 3.

**REPORT OF RESOLUTIONS
COMMITTEE NO. 3**

Dr. William H. Kose, MD, Hancock County, Chairman, presented the report of Resolutions Committee No. 3. The House took action on the report as follows:

**SUBSTITUTE RESOLUTION
NO. 52-88**

**Sex Education in Public Schools
(Replacing No. 52 & 53)**

RESOLVED, That the Ohio State Medical Association support H.B. 345 as passed by the Ohio House of Representatives to require the Board of Education of each county, village or city school district to prescribe a course of study in human growth and development for grades kindergarten through 12. Topics to be included are comprehensive sex education, sexually transmitted diseases and AIDS prevention and, be it further

RESOLVED, THAT THE OSMA COUNCIL PURSUE THROUGH APPROPRIATE CHANNELS THE IMPLEMENTATION OF A STANDARDIZED SEX EDUCATION CURRICULUM FOR GRADES K-12 IN THE STATE OF OHIO.

By official action, the House voted to amend Substitute Resolution No. 52-88, as indicated in capital letters with deletions as noted, and to adopt it as amended.

**SUBSTITUTE RESOLUTION
NO. 54-88**

AIDS Policy

(Replacing No. 54 & 55)

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION RECOGNIZES THAT THE CONFIRMED POSITIVE HIV INDIVIDUAL (TWO HIV TESTS AND A WESTERN BLOT) HAS AN INFECTIOUS DISEASE; AND, BE IT FURTHER

RESOLVED, That the Ohio State Medical Association go on record as recommending that the Ohio Department of Health (ODH) adopt the following infectious disease control requirements for the AIDS virus: requiring all laboratories and physicians to report confirmed positive HIV tests (two HIV tests and Western Blot) **DETERMINED**

AT OTHER THAN AN ANONYMOUS TESTING SITE to ODH AND LOCAL HEALTH DEPARTMENTS; requiring physicians and ODH AND LOCAL HEALTH

DEPARTMENTS to provide professional counseling for all individuals with confirmed positive HIV tests; requiring ODH to institute contact tracing in order to notify unsuspecting sexual partners who may have been exposed and should be tested; and, **THAT PHYSICIANS WHO REPORT THE NAMES OF INDIVIDUALS WHO TEST POSITIVE FOR HIV BE IMMUNE FROM LIABILITY;** and, be it further

RESOLVED, That OSMA recommend ODH set up more testing sites where people can go for HIV serologies if they fear they have been exposed to the virus; and, be it further

RESOLVED, That OSMA recommend HIV testing for immigrants, prisoners, military personnel, and affirm mandatory HIV testing of organ, tissue, blood and semen donors; and, be it further

RESOLVED, That OSMA recommend voluntary testing should be regularly provided for the following types of individuals who give an informed consent: patients at sexually transmitted disease clinics; patients at drug abuse clinics; pregnant women in high-risk areas in the first trimester of pregnancy; individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior seeking family planning services; and patients who require surgical or other invasive procedures who are from areas with a high incidence of AIDS or who engage in high-risk behaviors; and, be it further

RESOLVED, That OSMA recommend, as a matter of medical judgment, physicians should encourage voluntary HIV testing for individuals whose

history or clinical status warrant this measure; and, be it further

RESOLVED, That anonymous testing centers ~~develop a code system for retrieval of the identity of any confirmed positive HIV test;~~ **CONTINUE TO VIGOROUSLY ENCOURAGE INDIVIDUALS WHO TEST POSITIVE TO IDENTIFY THEIR CONTACTS FOR THE PURPOSE OF FURTHER TESTING;** and, be it further

RESOLVED, That all health-care providers, emergency medical personnel, undertakers and embalmers be encouraged to treat all bodies as if they have an infectious disease and undertake universal blood and body fluid precautions on all bodies as recommended by the Centers for Disease Control; and, be it further

RESOLVED, That all information and records containing any information which identifies a person who is seropositive for the AIDS virus be kept strictly confidential and that confidentiality guidelines be developed to protect the privacy of the HIV infected person, ~~except~~ **INCLUDING** when the information and records are released to health-care personnel who have a legitimate medical need to have access to the information in order to assist the patient or to protect the health of others; and, be it further

RESOLVED, That a physician receive a patient's informed consent to order an HIV serology, unless the test is medically necessary to avoid or minimize an immediate danger to the health or safety of the patient or another individual; and, be it further

RESOLVED, That ~~ALTHOUGH~~ insurance companies **MAY** have the right to order HIV testing prior to issuing health or life insurance; ~~however,~~ once a patient has obtained insurance, the company cannot cancel or refuse to renew the patient's policy based

solely on the fact that the policy holder has been diagnosed as having AIDS, an AIDS-related condition, or a confirmed positive HIV test; and, be it further

RESOLVED, That OSMA support a national, state and local catastrophic health insurance program to cover the individuals who are confirmed HIV positive and who are uninsurable; and, be it further

RESOLVED, That more programs be developed to educate the public on the AIDS epidemic; and, be it further

RESOLVED, That legislation be enacted to protect confirmed HIV positive individuals from discrimination in housing, public facilities, **EDUCATIONAL FACILITIES** and public transportation; and, be it further

RESOLVED, That a person not be discriminated against in his place of employment and not be terminated from his place of employment solely on the basis of a positive HIV test; and, be it further

RESOLVED, That OSMA advocate sufficient state funding for AIDS programs and AIDS public education.

RESOLVED, THAT UPON ADOPTION BY THE OSMA HOUSE OF DELEGATES THIS RESOLUTION BE FORWARDED TO THE AMA FOR CONSIDERATION BY THE HOUSE OF DELEGATES IN JUNE, 1988.

By official action, **the House voted to amend Substitute Resolution No. 54-88 as indicated in capital letters with deletions as amended.**

AMENDED RESOLUTION NO. 56-88

Universal Immunizations

RESOLVED, That the Ohio State Medical Association urge that as universally as possible infants and pre-school children be

immunized against at least diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps and German measles. Hemophilis influenza type B immunization should also be ~~considered~~

REQUIRED; and, be it further

RESOLVED, That the Ohio State Medical Association support such programs toward this end, that are acceptable to this Association under the guidelines under the Chapter 3313.671 of the Ohio Revised Code.

By official action, **the House voted to amend Amended Resolution No. 56-88 as indicated in capital letters with deletions as amended.**

AMENDED RESOLUTION NO. 57-88

American Pharmaceutical Association

RESOLVED, That the Ohio State Medical Association notify the American Medical Association to continue its surveillance of mail-order prescriptions; and, be it further

RESOLVED, That the OSMA ~~forcefully~~ **RESPECTFULLY** request that the American Pharmaceutical Association notify its members that prescriptions be refilled only on the physician's order; and, be it further

RESOLVED, That OSMA ~~forcefully~~ request that the American Pharmaceutical Association advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled, ~~and, be it further~~

~~RESOLVED, THAT A SIMILAR RESOLUTION BE REFERRED TO THE AMA.~~

By official action, **the House voted to amend Amended Resolution No. 57-88 as indicated in capital letters with deletions as amended.**

RESOLUTION NO. 58-88

Oppose Pharmaceutical Advertising

RESOLVED, That the Ohio State Medical Association adopt a policy and announce its opposition to marketing of prescription drugs to the public; and, be it further

RESOLVED, That the Ohio State Medical Association exercise its influence and propose similar policy at the national level through the American Medical Association.

By official action, the House voted to adopt Resolution No. 58-88.

AMENDED RESOLUTION NO. 59-88

Drug Paraphernalia

RESOLVED, That the OSMA-MSS encourage the OSMA through its Department of State Legislation (H.B. 135) to develop and/or support state legislation which appropriately addresses the sale, distribution and manufacture of drug paraphernalia; and, be it further

RESOLVED, That the OSMA publish in *OHIO Medicine* a report on its efforts in this area prior to the A-89 OSMA Annual Meeting.

By official action, the House voted to adopt Amended Resolution No. 59-88.

RESOLUTION NO. 60-88

Optometric Use of Drugs

RESOLVED, That the Ohio State Medical Association hereby reaffirms the principles of Resolution No. 58-77 which declared that the OSMA oppose as detrimental to the public interest any legislation which would authorize optometrists to use drugs for the purpose of diagnosing or treating systemic diseases or diseases and injuries of the eye.

By consent, the House adopted Resolution No. 60-88.

RESOLUTION NO. 61-88

Post-operative Ophthalmic Care

RESOLVED, That an ophthalmologist is uniquely qualified to perform eye surgery, including pre-surgical evaluation and post-operative management; and, be it further

RESOLVED, That an operating ophthalmologist's duties to a patient with respect to post-operative medical care are satisfied only if the ophthalmologist:

- a) Performs the patient's post-operative medical care throughout the patient's episode of illness;
- b) Arranges for the aspects of the patient's post-operative medical care not performed by the operating ophthalmologist to be provided throughout the patient's episode of illness by someone who is uniquely competent, willing and legally able to provide that care, with the consent, in advance of surgery, of both the patient and the person selected to provide that care; or
- c) Obtains the patient's fully informed consent, in advance of surgery, to the ophthalmologist's failure to comply with at least one of the two alternatives described in (a) or (b); and, be it further

RESOLVED, That a copy of this resolution be forwarded by the Ohio State Medical Association to the Ohio State Medical Board and that the Board be requested to adopt a policy statement reflecting the contents of this resolution.

By official action, the House referred Resolution No. 61-88 to the OSMA Council.

By official action, the House referred Resolution No. 61-88 to the OSMA Council.

SUBSTITUTE RESOLUTION NO. 62-88

Donation of Professional Time to Poor

RESOLVED, That the OSMA commend its members for continuing to donate professional time to serving the poor, without expectation of financial return; and, be it further

RESOLVED, That the OSMA Council formally initiate a study of the problems of the medically-underserved population in Ohio and report their findings and recommendations to the 1989 OSMA House of Delegates.

By official action, the House voted to adopt Substitute Resolution No. 62-88.

RESOLUTION NO. 63-88

Relationships of Physician With Managed Health-Care Plans

RESOLVED, That the Ohio State Medical Association inform its members of the desirability of physicians wishing to negotiate with Managed Health-Care Plans as a group to assume the structure of a professional corporation, one form of which is the Independent Practice Corporation, so that they may qualify as an integrated entity capable of assuming risk.

By official action, the House referred Resolution No. 63-88 to the OSMA Council.

AMENDED RESOLUTION NO. 64-88

State Medical Board Guidelines

RESOLVED, That the OSMA with the cooperation of the Ohio State Medical Board develop guidelines that inform the physician of his rights, duties and responsibilities when visited by a Medical Board Investigator; and, be it further

RESOLVED, That the State Medical Board investigators present these guidelines to the office staff when making a visit to a physician's private office; and, be it further

RESOLVED, That with each mailing of the biennial medical license a copy of the guidelines be included.

By official action, the House voted to adopt Amended Resolution No. 64-88.

RESOLUTION NO. 65-88

Autopsy Increase

RESOLVED, That the Ohio State Medical Association provide strong support for the revised JCAH standard GUIDELINES regarding autopsy. ~~increase—and notify all health care organizations in Ohio of this support.~~

By official action, the House voted to amend Resolution No. 65-88 as indicated in capital letters with deletions as noted, and to adopt it as amended.

RESOLUTION NO. 66-88
Amending Hospital Staff Bylaws to Provide for the Right to Legal Counsel

RESOLVED, That the House of Delegates call on the component societies of OSMA and the members of organized medical staffs in Ohio to seek amendments to their hospital staff bylaws providing for the right to personal and separate legal counsel of the physician's choosing in the following matters:

1. Denial, change in, suspension or revocation of medical staff membership;
2. Denial, involuntary reduction, suspension, or termination of clinical privileges. (This does not apply to temporary privileges.);
3. Non-renewal of medical staff membership;
4. Contested, involuntary imposition of significant consultation or monitoring requirements;
5. A reprimand, censure or any disciplinary action;
6. Anything that results in any adverse report to any state or federal agency.

By official action, the House referred Resolution No. 66-88 to the OSMA Council.

RESOLUTION NO. 67-88
Peer Review of Fees

RESOLVED, That the Council of the Ohio State Medical Association instruct the county societies on the terms and

conditions under which they can provide fee arbitration and mediation services to the members, to the public and to third-party carriers in such manner as to avoid violation of anti-trust statutes.

By consent, the House adopted Resolution No. 67-88.

AMENDED RESOLUTION
NO. 68-88

Public Education on Hazards of Tanning Parlors

RESOLVED, That the Ohio State Medical Association endorse the findings released by the FDA warning Americans that the use of UVA tanning booths and sunbeds pose potentially significant health risks to users and should be discouraged; and, be it further

RESOLVED, That OSMA undertake an educational campaign regarding the skin health and aging hazards of UVA overexposure; and, be it further

RESOLVED, That the OSMA suggest Ohio physicians obtain appropriate informational brochures available from the American Academy of Dermatology; and, be it further

RESOLVED, That OSMA support, in conjunction with Ohio's various dermatological societies, an educational campaign to secure appropriate state regulatory and oversight activities for tanning parlor facilities to reduce improper and dangerous exposure to ultraviolet light by our patients and general public consumers and that enforcement of current regulations be intensified; and, be it further

RESOLVED, That this regulation be transmitted to the American Medical Association for consideration at its 1988 annual meeting.

By official action, the House voted to adopt Amended Resolution No. 68-88.

RESOLUTION NO. 69-88
Expediting Communications for Freedom

By official action, the House rejected Resolution No. 69-88.

RESOLUTION NO. 70-88
Violence in Movies, Television and Videotapes

RESOLVED, That the Ohio State Medical Association continue to instruct its members to the damage of the violence and the horror in films on television, videos and movies; and, be it further

RESOLVED, That all members of the health-care field pressure for the decrease in such violence and horror.

By consent, the House adopted Resolution No. 70-88.

RESOLUTION NO. 71-88
Helicopter Ambulance Safety
By consent, the House rejected Resolution No. 71-88.

SUBSTITUTE EMERGENCY
RESOLUTION NO. 02-88
Nursing Shortage —

Implementation of American Medical Association Board of Trustees Report CC I-88 (Replacing No. 02 & 03)

RESOLVED, That the Ohio State Medical Association support CC's recommendations *within the framework of current levels of nursing education*; and, be it further

RESOLVED, That OSMA urge the AMA to open dialogue with the American Nurses Association to discover creative methods to increase enrollment in nursing education programs, to retain bedside nurses, to provide financial incentives, and to provide incentives for "retired nurses" to return to bedside nursing; and be it further

RESOLVED, That upon adoption by the OSMA House of Delegates, this resolution be forwarded to the AMA for

consideration by the House of Delegates in June, 1988.

By official action, the House voted to adopt Substitute Emergency Resolution No. 02-88.

PRESIDENT'S ADDRESS

President Irons prefaced his remarks with a special slide show highlighting OSMA's activities and programs during the past year.

He began his address by reporting that the leadership and staff of OSMA have kept the promise to be "In Charge" of medicine's changing environment, from both clinical and socioeconomic standpoints, in order to protect physicians' rights and the rights of patients.

He said that OSMA has one of the most aggressive and successful legislative track records in the country. He cited the significant growth of OMPAC as a major factor, as well as the successful passage of tort reform legislation.

President Irons presented several examples of the proactive stance OSMA has taken on important issues:

- Medicare "Medical Necessity" Letters. OSMA was on the verge of filing a legal action against the Health Care Financing Administration when HCFA offered a compromise.
- Ohio Project Elderly Needy (OPEN). This is OSMA's program at the county medical society level which impacts positively on the physician-patient relationship.
- Reactivated Cancer Committee. The Committee has developed a cancer checklist for physicians' offices and guidelines for cancer screening centers.
- AIDS Task Force. These dedicated physicians have addressed the issue in a calm and rational manner to the Ohio General Assembly, the membership, and to the public.
- Public Relations. OSMA prepared and disseminated a

series of brochures on socioeconomic issues for patients.

- Ombudsman. This program helps individual physicians with reimbursement problems as well as addressing broader issues with Medicare, Medicaid, Workers Compensation and other government medical programs.

As co-chairman of the Ohio Delegation to the American Medical Association, President Irons paid tribute to the accomplishments of the delegates.

He cited the outstanding work of OSMA committees during the year — with special emphasis on the recruitment of young physicians for the committees and task forces.

On a more sober note, he mentioned the division among medicine's ranks, namely the specialty societies. He called for turf considerations to be downgraded in favor of working together and speaking as one.

President Irons cited the emergence of PICO from its recent crisis to the point of being a "lean, mean company with adequate reserves," better able to meet today's demands in the malpractice coverage arena.

In looking to the future, President Irons called for strengthening of the relationship between organized medicine and the academic world of medicine, increased support of the up-and-coming OSMA Medical Staff Section, prioritization of our services to members, and strengthening of the individual physician-patient relationship. He emphasized that physicians must join hands with patients to help them understand that we are their best and most loyal advocate.

In closing, President Irons expressed his heartfelt appreciation for the opportunity to be "In Charge" during this challenging time.

The House accepted the report by acclamation and it was filed.

THE REPORT OF RESOLUTIONS COMMITTEE NO. 3, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

INAUGURAL CEREMONY

Henry Krueger, MD, escorted Mrs. Baumgartner and the Baumgartner children to the rostrum.

Dr. Albers administered the Presidential Oath of Office to Dr. Baumgartner. Dr. Baumgartner introduced the members of his family to the House. Dr. Irons then presented to Dr. Baumgartner the official gavel and the President's Medallion. Dr. Baumgartner briefly addressed the House. The Baumgartner family was given a standing ovation.

S. Baird Pfahl, Jr., MD, escorted Mrs. Irons to the rostrum.

Dr. Baumgartner presented to Dr. Irons the Past President's pin, the President's plaque, a replica of the President's Medallion to Mrs. Irons and a replica of the President's Medallion to Dr. Irons. Dr. Baumgartner presented a personal gift to Dr. Irons.

Dr. Irons thanked the OSMA Council, the House, the OSMA staff and his staff for their support during his year as President.

The House gave Dr. and Mrs. Irons a standing ovation.

There being no further business, the House of Delegates adjourned, sine die.

ATTEST: Herbert E. Gillen
Executive Director

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Editor's Note: *The purpose of this Bulletin, written by the subcommittee on loss awareness through the OSMA's Task Force on Professional Liability, is to make Ohio physicians aware of situations which may lead to liability lawsuits. It is not intended to provide legal advice or counsel, nor will the Bulletin attempt to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.*

Medical Records — II

Our focus on office medical records which began last month in the "Loss Awareness Bulletin" continues from a different perspective.

It has been said that medical records are "witnesses whose memories never fade." Largely for this reason, an office medical record can become the physician's strongest ally — or enemy — in malpractice litigation.

In our last issue, we offered recommendations for increasing the accuracy and the completeness of medical records. Our attention now will turn to ways in which medical records could work against a physician in litigation — with suggestions to avoid this from happening.

1. A medical record can cause difficulty for the physician when it fails to reflect the application of education, training and experience to a clinical situation. This failure could prompt a jury to assume that even *they* could have done a better job of treating the patient.

2. A medical record can create problems if it fails to reflect the complexity of a difficult clinical problem. This could become a strong point of evidence for the patient and his attorney, because it could suggest that improper professional attention was paid to the problem.

3. The medical record also is incomplete — and potentially troublesome — if it fails to document a diagnostic and therapeutic plan and the rationale

behind it. The lack of such information could lead a jury to determine that no such plan or rationale existed.

4. Similar difficulties could arise in litigation if the physician's record fails to note a patient's response to treatment, and any indicated modification or deviation from the original treatment plan. The lack of this information could suggest little or no adequate follow-up.

If you were to disappear suddenly, could your office chart enable another physician to step in and provide appropriate care?

Although all four situations above are critical, the last two are the hub of most documentation problems in malpractice cases.

When either (or both) situations exist in a malpractice case, it could suggest the absence of "the physician's exercise of medical judgment." This component can be critical in the defense of a claim. If the patient's record does not reflect the exercise of medical

judgment, a jury could conclude that this essential element of good patient care simply did not happen, despite the physician's protests to the contrary.

The need for accurate and complete medical records will never lessen, and continued attention must be directed toward the components of an adequate medical record. No list or protocol ever is going to be complete, but here is one guideline: If you were to disappear suddenly, could your office chart enable another physician to step in and provide appropriate and effective care?

Good records, coupled with other elements such as effective doctor-patient communication and attention to other practice details can measurably lessen a physician's exposure to malpractice claims.

OSMA

Hot numbers

The Epilepsy Foundation of America's toll-free telephone service provides basic, up-to-date information on epilepsy to both the general public and medical professionals, and responds to questions on education, employment, legal matters, income support and counseling, as well as medical questions ranging from referrals to surgery and medicine.

The toll-free number is 1-800-EFA-1000.



Donavin A. Baumgartner, Jr., MD: A Renaissance President

By Karen S. Edwards

Donavin A. Baumgartner, Jr., MD, OSMA's new president, enters the room appearing a little rushed. Perhaps that's to be expected from a surgeon who directs a Class I trauma center. After all, one doesn't shuffle in an emergency room.

Yet even removed from the urgent care setting, Dr. Baumgartner generates an intense energy. It keeps him poised on the edge of his seat — as though, at any minute, he will leap into action. You're not surprised to learn he used to relax by racing cars.

Now, however, at 58, the man has different races to run.

"You know," he says, leaning forward, "my father (a physician) once told me his only regret was that he didn't become more involved in organized medicine."

For the son, however, involvement comes easily. He enjoys telling the story about how it all started.

"I was walking down the hall with a colleague, and I asked him how I could get on the (Cleveland) Academy's Emergency and Trauma Committee. He turned to me and said, 'you're on.' "

Admittedly, the colleague happened to be chairing the committee at the time, but Dr. Baumgartner insists that becoming involved in organized medicine can be just that simple.

"Once you get involved, and you see the changes that occur because of your participation, your involvement steamrolls. You get hooked."

Dr. Baumgartner has been hooked since that day in 1968 when he was so quickly added to the Cleveland Academy's trauma

committee. Since then, he has served on numerous committees at the local level including chairing, at various times, the honors, nominating, resolutions, travel, professional liability and membership committees. His interest in communication led him to a post as assistant editor of *Cleveland Physician* magazine, a position he held for eight years. Then, from 1979-80, he served as President of the Academy of Medicine of Cleveland.

Dr. Baumgartner's initial involvement with the OSMA came in 1972, when he was elected a member of the Fifth District Delegation, representing Cuyahoga County. In 1983, he became Fifth District Councilor, and has since assumed seats on various OSMA committees, including Auditing and Appropriations, the task force on professional liability and

"If I project any image at all, I hope it's the image of a team player . . ."

membership.

It's no coincidence that membership continues to appear and reappear in Dr. Baumgartner's background. Recruitment is a game he's good at.

"Persistence pays," he says with a smile.

But it's more than persistence. It's an intuitive "salesmanship," if you will — an ability to correctly gauge an approach, then follow through.

"Sometimes, it's simply a matter of asking them to join. Some people have never been asked," he says.

Others need to be cajoled. He recently approached one female radiologist who had been consistently turning down requests to join, with an impish sense of humor.

"Why not do something wild and crazy this year?" he asked her.

"What's that?" she responded.

"Join the OSMA."

It was an offer she couldn't refuse.

Then there are the diehard non-members who offer a different kind of challenge, say Dr. Baumgartner. He approaches each one personally and individually.

"It's best if they give me reasons why they won't join," he comments.

Then, it's like tossing down a gauntlet. Each feint can be neatly parried.

"I can't afford to join . . ."

they'll say.

"You can't afford not to join," he'll counter.

"What has the OSMA done for me?" they'll cry.

He pulls out the patient education brochures, the Medicare "medical necessity" letters. He enumerates the legislation that's being followed.

"But you can't get anywhere . . . it's all political," comes the next thrust.

Dr. Baumgartner edges forward in his seat.

"There is this image out there that organized medicine is run by a group of gray-haired old men who make all the decisions, but it's not true. If you show the interest and you want to do the work, you can go up the ladder."

Not everyone wants to, of course. Leadership is a personal decision, but grassroots involvement in organized medicine is paramount to the profession's success in the future, says Dr. Baumgartner.

"You can't, realistically, stop all the adverse changes taking place today in medicine, but organized medicine can and does stop a large percentage of them."

Increased membership means a stronger voice in the direction medicine is heading, he adds — but that voice must be a unified one, he cautions — one that represents all physicians.

In remarks before the House of Delegates, following his installation

as president, Dr. Baumgartner put it more succinctly:

"The old play on words, 'We must all hang together or certainly we shall all hang separately' is even more true today. Those who would destroy the profession are playing a serious game of divide and conquer . . . If we do not reunite as physicians, the battle is certainly lost, and we will be to blame." (The complete text of Dr. Baumgartner's speech can be found in this month's "Presidential Perspectives.")

"If I project any image at all," he reflects now, "I hope it's the image of a team player."

He points to the Ohio delegation to the AMA as a good example of team playing. As he notes, its members represent a wide variety of disciplines, backgrounds and, for that matter, opinion.

"But when we deliver our message to the AMA House, it's a unified message, and that's important for medicine."

Wilma Bergfeld, MD, immediate past president of the Cleveland Academy of Medicine, and the first woman to hold that position, believes Dr. Baumgartner is trying hard to ensure that unified physician voice.

"He works diligently to get minority groups involved in organized medicine so that all doctors and all viewpoints will be represented," she says.

Strengthening membership and encouraging physician unity are



two of the goals he has selected for himself this year. There is a third — communication.

"Certainly communication with each other is important, but so is communication with our patients," he says.

Presenting the public with the facts about what is happening to their health care may create some new allies for the medical profession, he says — and it is toward that end that he endorses the patient brochures developed by the OSMA's Department of Communications under the direction of his predecessor, D. Ross Irons, MD. It's a project that is certain to continue under his administration, he says.

It is not, however, the only project he will be undertaking — nor the only subject he plans to

address.

There is the quality assurance issue, for example, and the "medical necessity" situation with Medicare that may yet result in a lawsuit, he says.

"Before we see any basic changes in the liability situation, one of two things will have to happen. Either the public will have to feel a crunch or there will have to be a basic change in the tort system."

Of course, he adds, it would also be helpful if the courts would adhere to the definition of malpractice before it considers trying a case.

"Malpractice is injury to a patient as the result of a failure of a physician to directly meet routine standards of care," he says.

In reality, though, physicians

today are held to a level of "perfection in retrospect," which Dr. Baumgartner describes as unrealistic.

"If we were held in actual practice to the legal definition, I doubt there would be a liability problem," he notes.

Dr. Baumgartner expresses concern, too, about the issue of a physician surplus.

"I don't think there is reason to panic, yet," he says. "The perceived surplus seems to be more of a distribution problem, both from a geographical and specialty standpoint."

On the other hand, he doesn't want to see medicine fall into the same situation that the law profession now finds itself in.

"A prominent attorney friend told me we could shut down all the law schools tomorrow, and we would never notice a difference for five years."

Obviously, there are numerous issues facing medicine that organized medicine, and certainly the individual at the helm of organized medicine, need to address. How successfully will Donavin Baumgartner, Jr., MD, meet the challenges that lie ahead?

His colleagues are confident in his ability.

"He was educated at the best schools (Dr. Baumgartner graduated Phi Beta Kappa from Princeton University in 1952 and from Harvard Medical School four years later) and he has the best credentials for the job," says D. Ross Irons, MD, OSMA's immediate past president.

According to Dr. Irons, those credentials include an ability to assess a situation quickly and respond to it authoritatively.

"He is a doer who is used to making decisions," he notes. "And





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Donavin A. Baumgartner, Jr., MD . . . continued

he is not afraid to face the tough issues. He will definitely not keep a low profile during his year as president."

In fact, Dr. Irons says his successor is probably the best candidate to carry on his legacy of a tough, proactive presidency.

Theodore Castele, MD, a Cleveland radiologist and Chairman of the Ohio delegation to the AMA agrees.

"For two years, now, back to back, we have had two aggressive, action-oriented presidents who have recognized that physicians can't afford to stand around forever, debating the issues. Instead, these individuals have moved ahead to solve them, and that's been good for the OSMA."

Dr. Castele then becomes more specific.

"Each president brings his or her own unique approach to the problems facing medicine. Donavin has certain special abilities and characteristics which, when combined, will make him a strong and effective president."

He counts them off on his fingers.

"One, he has been very active at all levels of organized medicine, and has spent a number of years in this area as a leader. Two, he has a keen mind and is able to rapidly analyze problems. Three, he has the ability to gather others to his point of view and move things forward. I see him as a very action-oriented person."

And an unselfish one, adds Dr. Wilma Bergfeld.

"He has given up active days of practice to attend committee meetings, or to go to the statehouse to testify on bills that affect the practice of medicine," she says.

"He has pledged, up front, to represent physicians in those issues facing medicine, and he has done

so frequently, whether it was convenient for him or not," she adds.

And Dr. Bergfeld is comfortable with that representation.

"Donavin is able to grasp the big picture and to articulate medicine's views effectively."

Both Dr. Castele and Dr. Bergfeld paint, too, a portrait of a competent and concerned physician — one who fights as hard for his patients as he does for medicine.

"He has used his leadership abilities to obtain the finest and most appropriate care for his patients," says Dr. Castele.

"And he seeks additional training for himself to accomplish this end," adds Dr. Bergfeld.

Yet despite all of medicine's demands and Dr. Baumgartner's ongoing commitment to them, he finds time for additional activities as well. He is, in effect, a renaissance man — one who maintains an interest in and enjoys a vast variety of different subjects.

Ask him about wines, for example. As a member of four different societies and a wine instructor, certified by the society of wine educators, chances are he'll have the answers. His interest in cultural activities has led him to seek membership in Cleveland's medical arts club — a group comprised of local physicians who meet to discuss and learn more about non-medical subjects.

Married for 36 years to the former Marilyn Hoffman, he and "Mickey" are parents to Donavin III, Karen and Peter — and are grandparents as well.

His interest in race cars, alluded to earlier, was no passing fancy, incidentally. When Dr. Baumgartner was actively racing, he held track records at three different raceways including

1. Martines C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.

2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium, San Francisco, October 1987.

Watkins Glen. And he has his pilot's license — "Though I don't have much time to fly anymore," he admits.

Small wonder.

In fact, if his strong commitment to medicine — and to his patients — is any indication at all, it appears as though Donavin A. Baumgartner, Jr., MD — husband, father, renaissance man, physician, and now, OSMA president — is apt to stay grounded for some time to come. **OSMA.**

Karen S. Edwards is Executive Editor of OHIO Medicine.

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Second Opinion . . .

continued from page 605

world can, or will ever be able to claim truthfully that they are spending as much as could be desired on medical care in all its aspects."¹

The latest "crisis in the NHS" is fueled by two issues. Firstly, although the government is spending more than any other government in history on health (how Mrs. Thatcher reminds us of this!), most of the new money goes on pay awards to health workers. Thus, development money to provide new services for patients and new jobs for doctors and nurses in order to expand the system has remained low and in some areas actually decreased. This has resulted in district health authorities having to make some fairly draconian decisions in order to balance their books.

An interesting paradox often exists when the policy of more community management of disease, popular with both the people and the government, results in the closure of a small hospital which is no longer required. The

shutting of these institutions, frequently converted workhouses, are suddenly viewed by the local people and a parochial press as an issue worth sacrificing all good sense and logic for.

The second reason for the "crisis" is a product of our recent economic success. In his last budget, the Chancellor of the Exchequer was in a position to make tax cuts. Many people were saying that instead of reducing the basic rate of the income tax from 27 percent to 25 percent, he should inject that money into the National Health Service.

These issues, coupled with the usual outrageous reporting in the press, has maintained the health service debate in the public's mind for longer than is usual. Indeed, we are fast approaching having to actually respond to that most dangerous of sayings "something has to be done."

Instead of pouring more and more money into a system which was fashioned from a pre- and post-war social structure, the time has arrived to rethink the whole system. At the time of the conception of the National Health

Service, people flushed with the success of the ability of antibiotics to combat infectious disease actually thought that illness would be significantly reduced, thereby reducing demands on the health service. It was also a time of food and petrol rationing so the concept of waiting for non life-threatening operations was familiar to most people. People's expectations of medical care and the type of care available has changed beyond the wildest dreams of 1948.

An injection of cash now would be the equivalent of placing a Band-Aid on a leaking dam. It buys a small piece of time, but just postpones the inevitable. The NHS has been and still is a success. No other country provides a comprehensive system of health care at the lowest cost as measured by the proportion of national income devoted to it. Indeed, with the spiraling costs of health care in the USA, it was interesting that a major American study of the NHS was undertaken recently.²

If we were now in 1948 designing a health-care system with the benefit of foresight, we might well go for a less monolithic model. Moreover, the NHS is in many ways a monument to a vanishing age. If hypocrisy is the tribute vice pays to virtue, the NHS is the tribute a non-egalitarian society now pays to social justice.³

Now if I wanted to be really critical, I could look at the American system of health care . . . !

Temptation! Temptation! OSMA

Huw P. Williams, MD, is a visiting professor in the Department of Family Medicine, Ohio State University College of Medicine, Columbus.

References

1. British Medical Association. Health Services Financing, London BMA, 1970.
2. Aaron, H.J., Schwartz, W.B. The Painful Prescription. Washington, DC: The Brookings Institution, 1984.
3. Klein, R. Financing Health Care: The Three Options. *British Medical Journal*, 1988, 296, 734.



A New Look at Medical Education

A third-year medical student sits in the relative peace of a computer center — her task, to learn as much as possible about pupillary light response, normal and pathological, in the next hour. Eagerly she sits down, facing the terminal screen. She hits a button and a pair of bright eyes stare back at her from the screen. She picks up a penlight and shines it into the computer-generated image of the right eye. Its pupil immediately constricts, as does its partner, in normal consensual response. Then, both eyes leave the screen — to be replaced by a series of questions. The student responds to each, then asks the computer to proceed to the next exercise. Instantly, a new set of eyes appear, mimicking all of the symptoms of Horner's syndrome. The student shines her penlight in each of the eyes several times to make absolutely sure of the symptoms before she makes her diagnosis.

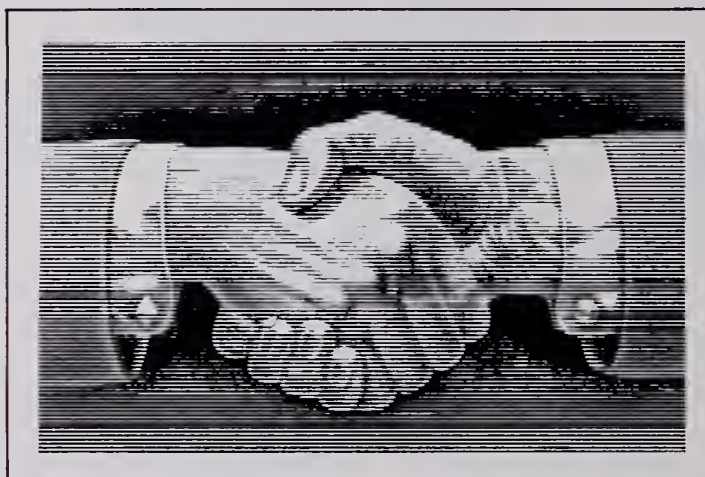
Despite the futuristic feel of this

scene, the year is 1988, and the actions described above may soon be repeated by many students at Wright State University's School of Medicine in Dayton. A simple IBM PC or PC-compatible computer is presently running a program called "The Computerized Pupil," written by Lori Kuehne, a second-year medical student at Wright State under the guidance of John Bullock, MD and Blair Rowley. Dr. Bullock is professor and chair of ophthalmology at Wright State; Rowley is professor and chair of Wright State's biomedical engineering program. (Kuehne herself holds a BS in biomedical engineering from Wright State.)

The project began when Dr. Bullock decided it would be useful to have a teaching tool to stimulate normal and pathological pupil responses, as it is difficult for health professionals to obtain experience with abnormal pupil reactions. Even in an eye clinic, some of the

By Cindy Smith

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Wright State medical student Lori Kuehne (seated) demonstrates "The Computerized Pupil." She was guided in developing the new computer program by John D. Bullock, MD (left) and Blair Rowley, PhD.

pathological responses are rare, and a student may only be able to glimpse such responses once, if at all. Rowley suggested that a computer might be able to simulate the pupil response adequately and suggested that Lori Kuehne, with her dual background in medicine and engineering, might be interested in working on the project.

Kuehne wrote much of the program over the summer. The program, written in BASIC and able to fit on one floppy disk, is menu-driven and, according to all reports, very easy to use. The penlight itself is plugged into the computer, and once it is touched to the pupil of one of the eyes displayed on the screen, the pupil immediately constricts — or doesn't, depending on the pathological condition. In addition to showing

the "normal" pupil, the computer also generates eyes with Marcus Gunn, Adie's pupil, Horner's syndrome and others.

"With this program, you can get almost a lifetime's experience with pupillary abnormalities in less than an hour. You'd have to hang around an eye clinic for a very long time to see patients with this many different problems," comments Dr. Bullock.

Does this mean, then, the possibility of more medical education by computer in the future?

"I think that computers are an upcoming area in medical education," notes Kuehne, and yes, "We'll see a lot more programs like this in the future."

Bullock, Rowley and Kuehne are planning to test the "Computerized Pupil" program

this summer with Wright State students, but they see potential applications in the training of other health professionals as well, since nurses and technicians often dilate pupils for examination and also need to be exposed to common pupil abnormalities.

Development of the "Computerized Pupil" was supported by funds from Wright State's School of Medicine and from Ervin J. Nutter, a Dayton-area business leader and member of Wright State University's Board of Trustees. **OSMA**

Cindy J. Smith is a second-year medical student at Wright State University's School of Medicine.



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PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

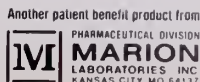
HOW SUPPLIED

CARAFATE (sucralfate) 1 gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Issued 1/87

Reference:

1. Elakim R, Ophir M, Rachmilewitz D. *J Clin Gastroenterol* 1987; 9(4):395-399.



1337E8

including guarantee, relocation, etc., tailored to your needs. Contact Rick Addis, Van Wert County Hospital, Van Wert, OH, 45891 (419) 238-2390.

LOCUM TENENS — Opportunities available throughout the country. Work parttime or fulltime, at your convenience. Malpractice insurance, housing and transportation provided. Contact: LOCUM Medical Group, 30100 Chagrin Blvd., Cleveland, OH 44124. Or call: 1-800-752-5515 (in Ohio, 1-216-464-2125).

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continued on page 692

Announcing a new benefit beyond price alone.

Advanced Formula

Mytrex[®]

(nystatin-triamcinolone
acetonide)

New — fragrance-free formula

- ☐ Avoids the #1 irritant in cutaneous reactions¹
- ☐ No methylparaben, propylparaben, or ethylenediamine
- ☐ Virtually nonsensitizing vanishing cream base

Uncompromised anticandidal effectiveness

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Convenience for compliance

- ☐ b.i.d. regimen
- ☐ Both popular dosage forms—cream and ointment

...and still economical

Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.



SAVAGE LABORATORIES
a division of Altana, Inc.
Melville, New York 11747



Mytrex[®]

CREAM AND
OINTMENT, USP

(nystatin-triamcinolone acetate)

Brief Summary of Prescribing Information

For Dermatologic Use Only
Not for Ophthalmic Use

INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.

CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.

PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see **DOSAGE AND ADMINISTRATION**). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see **PRECAUTIONS, Pediatric Use**). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetate, treatment should be discontinued and appropriate therapy instituted.

Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped so as to be occluded (see **DOSAGE AND ADMINISTRATION**).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test; ACTH stimulation test.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetate. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetate Cream cleared or significantly ameliorated the disease state in most patients. Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio. HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetate in clinical studies.

Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.

The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.

DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX[®] (Nystatin-Triamcinolone Acetate) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX[®] is usually applied to the affected area twice daily in the morning and evening. MYTREX[®] should be discontinued if symptoms persist after 25 days of therapy. (See **PRECAUTIONS, Laboratory Tests**). MYTREX[®] should not be used with occlusive dressings.

Caution: Federal law prohibits dispensing without prescription.

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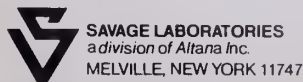
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continued on page 694



R 4/87



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**Just one part of
pain relief therapy.**

**Vicodin® provides greater
patient acceptance**

COMPARATIVE PHARMACOLOGY OF THREE ANALGESICS

	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- ◆ Vicodin offers: less nausea, less sedation, less constipation.

**...and longer lasting pain relief—
up to 6 hours.**

- ◆ Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.¹
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Plus...

- ◆ Vicodin offers the convenience of CIII prescribing.
- ◆ Dosage flexibility—1 tablet every 4 to 6 hours or 2 tablets every 4 to 6 hours (up to 8 tablets in 24 hours).

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

-vicodin[®]

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) and acetaminophen 500 mg

The original hydrocodone analgesic.

Please see adjacent page for brief summary of prescribing information



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reaction: VICODIN contains sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than non-asthmatic people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. (See ADVERSE REACTIONS: Respiratory Depression).

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: As with any narcotic analgesic agent, VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind. **Information for Patients:** VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1.0 mg/kg q6h, and paregoric 2 to 4 drops/kg q4h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.

Labor and Delivery: As with all narcotics, administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. The antiemetic phenothiazines are useful in suppressing these effects; however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS)

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use and the incidence of untoward effects is dose related.

The usual adult dosage is one or two tablets every four to six hours as needed for pain. The total 24 hour dose should not exceed 8 tablets.

Revised June, 1987

5803

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Applications are being accepted for director of an aggressive state program to rehabilitate industrially disabled workers. Program offers comprehensive rehabilitation planning and treatment tailored to individual needs with unique incentives for patient and employer cooperation. Program services are extended through teams of rehabilitation consultants, registered nurses and physicians.

Director will develop program goals and policies, direct over 500 professional and support personnel and represent the Industrial Commission to medical, labor, employer and other interest groups.

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2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, OHIO Medicine, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be **DOUBLE SPACED** with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) should bear the figure number and author's name on back. When pertinent, the top of the photograph should be indicated. Do not clip or write on the back of the photos with a hard pencil, etc.

(b). The author should have written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

11. **CASE HISTORIES.** The *Journal* does not accept case histories.

12. **EDITORIAL ASSISTANCE.** Michelle Carlson, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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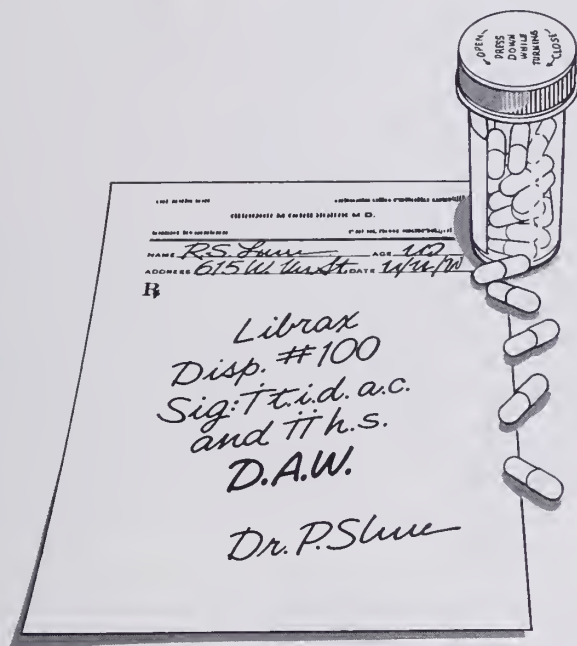
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For the brain/bowel conflict of IBS*



Specify
Adjunctive

LIBRAX[®]

THE PEACEMAKER.

Antianxiety
Antisecretory
Antispasmodic

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

- * **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such

as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

P I 0288



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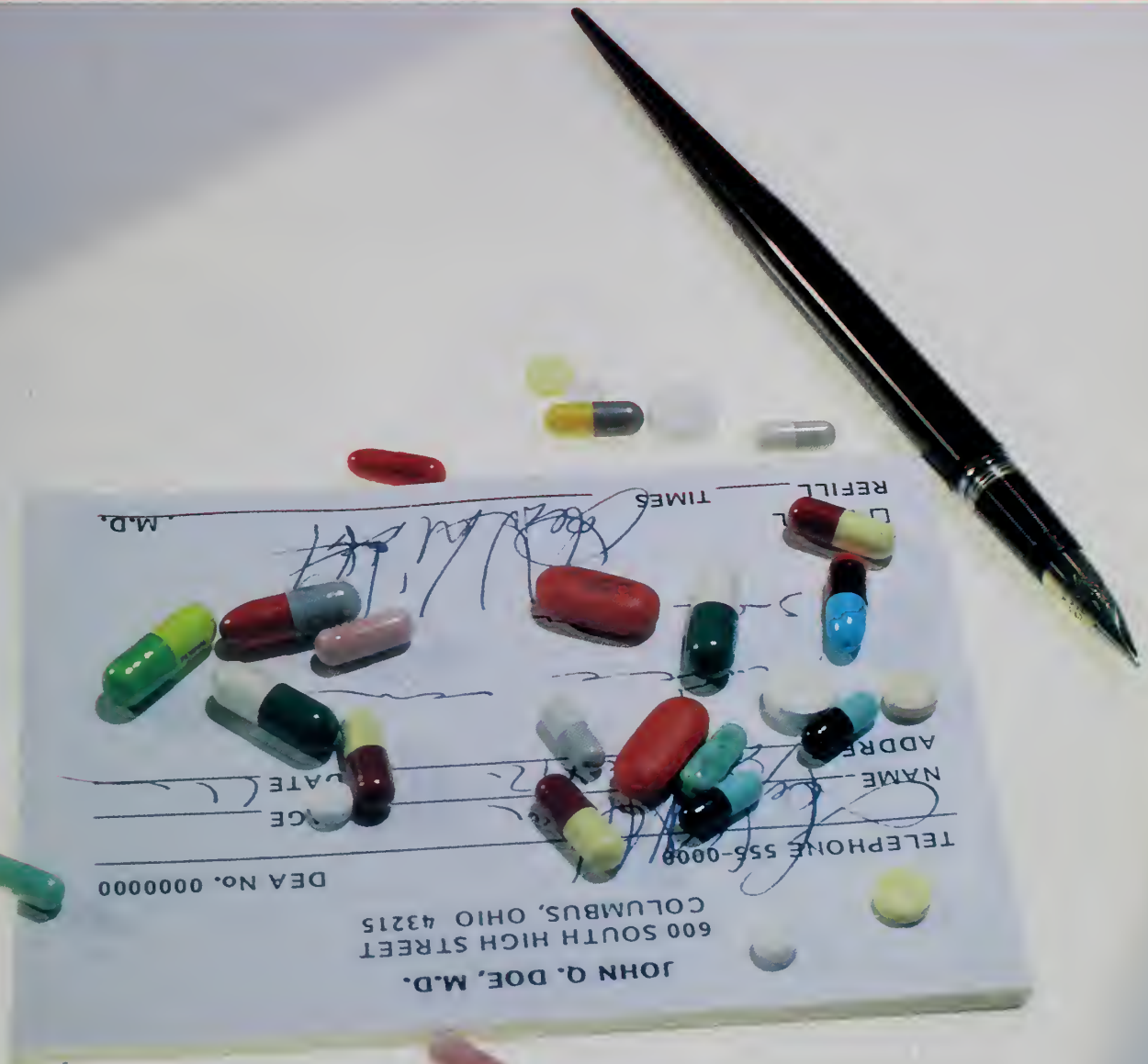


OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 84. NO. 9

SEPTEMBER 1988



Generic vs. Brand Name: The Controversy Continues

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In the depressed and anxious patient

See Improvement



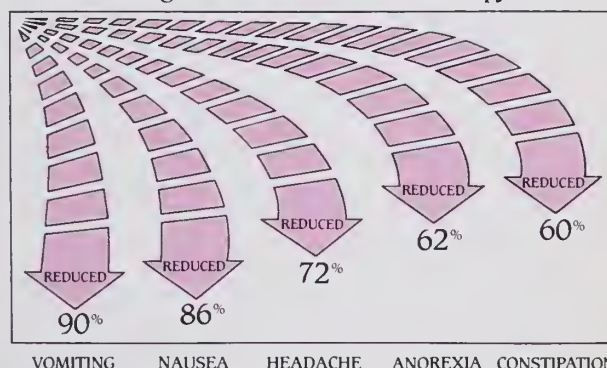
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In The First Week...¹

And The Weeks That Follow

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose¹
- ➡ First week reduction in somatic symptoms¹

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



VOMITING NAUSEA HEADACHE ANOREXIA CONSTIPATION

*Patients often presented with more than one somatic symptom.

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Limbitrol DS[®]

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) [Ⓢ]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

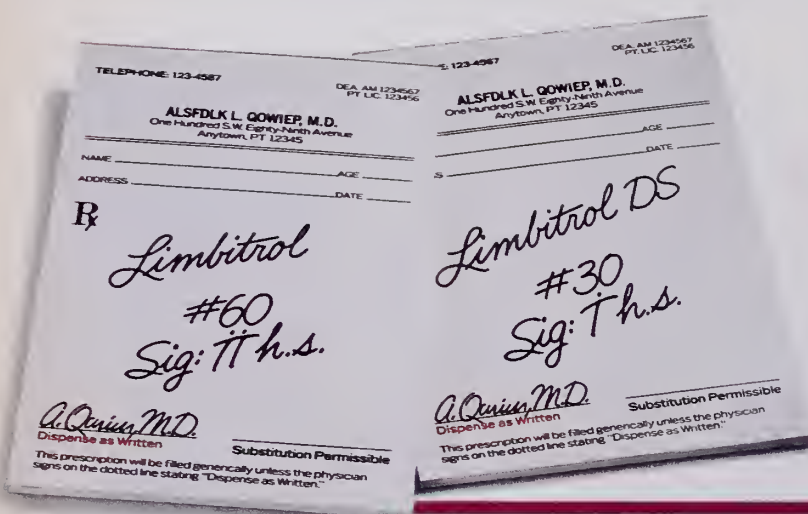
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Please see summary of product information on following page.



In moderate depression and anxiety

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose¹
- ➡ First week improvement in somatic symptoms¹
- ➡ 50% greater improvement with Limbitrol in the first week than with amitriptyline alone²



Protect Your Prescribing Decision:
Specify "Do not substitute."

Limbitrol®
Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) ^(IV)

Limbitrol DS®
Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) ^(IV)

References: 1. Data on file, Hoffmann-La Roche, Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

Limbitrol® ^(IV)

Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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FROM THE EDITOR

Generic Confusion

In 1984, federal law facilitated the entry of generic drugs into the marketplace. Confusion, it seems, has reigned ever since.

Whether or not to prescribe generic or brand name drugs has become a hot question among today's physicians, and one this issue of *OHIO Medicine* hopes to address.

Our lead article, by Associate Editor Deborah Athy, examines the nature of generic drugs, then digs in for a closer look at some of the controversies which surround these drugs — and why physicians may be hesitant to prescribe them.

Perhaps one of the most disturbing issues raised by the generic vs. brand name controversy is whether or not the prescription you write is being filled as ordered. Our article "Is Your Patient Getting What You Ordered?" examines this topic from both the physicians' and pharmacists' perspective.

Our third article, by Editorial Assistant Michelle Carlson, presents an informal survey of some of your colleagues — and what they have elected to do about prescribing generics or brand names. Perhaps their reasons for their choices may help you decide what to do in similar circumstances.

This month's "Ohio Medicine" section features articles on a model teen pregnancy program, set up in Marion and recently recognized by the AMA, a medical mystery which has recently

surfaced in the state — the return of rheumatic fever — and the Cleveland Academy trauma guidelines.

If you have suggestions for our 1989 editorial calendar, please let us know . . .

We hope *OHIO Medicine* is keeping you informed about timely topics in the rapidly changing medical environment. If you have any suggestions for future subjects you would like us to cover, please let us know — either by writing us, or giving us a call. We are presently in the process of drawing up, with our advisory board, our editorial calendar for 1989, and we would be happy to consider your ideas.

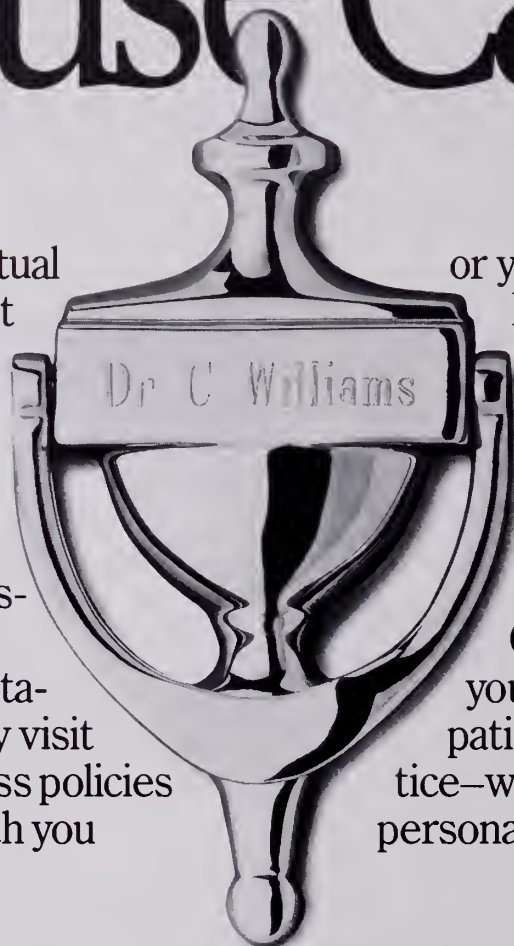
Next month, we'll be publishing the program for the OSMA's Clinical Update meeting, which will take place in Cincinnati in November. Don't miss it (the issue or the meeting!)

Until then . . .

Karen S. Edwards

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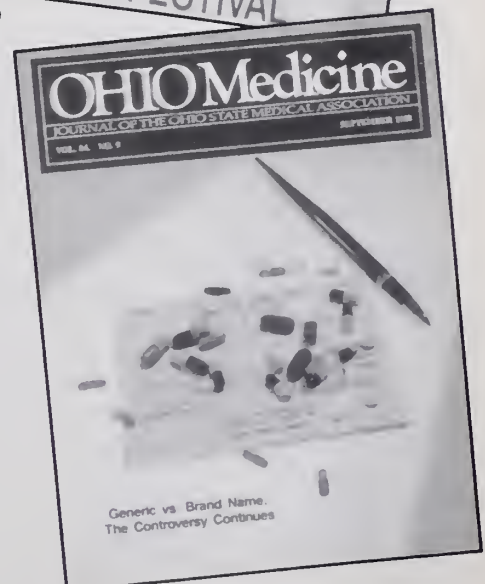
This month's cover was photographed by free-lance artist-photographer Larry Hamill.

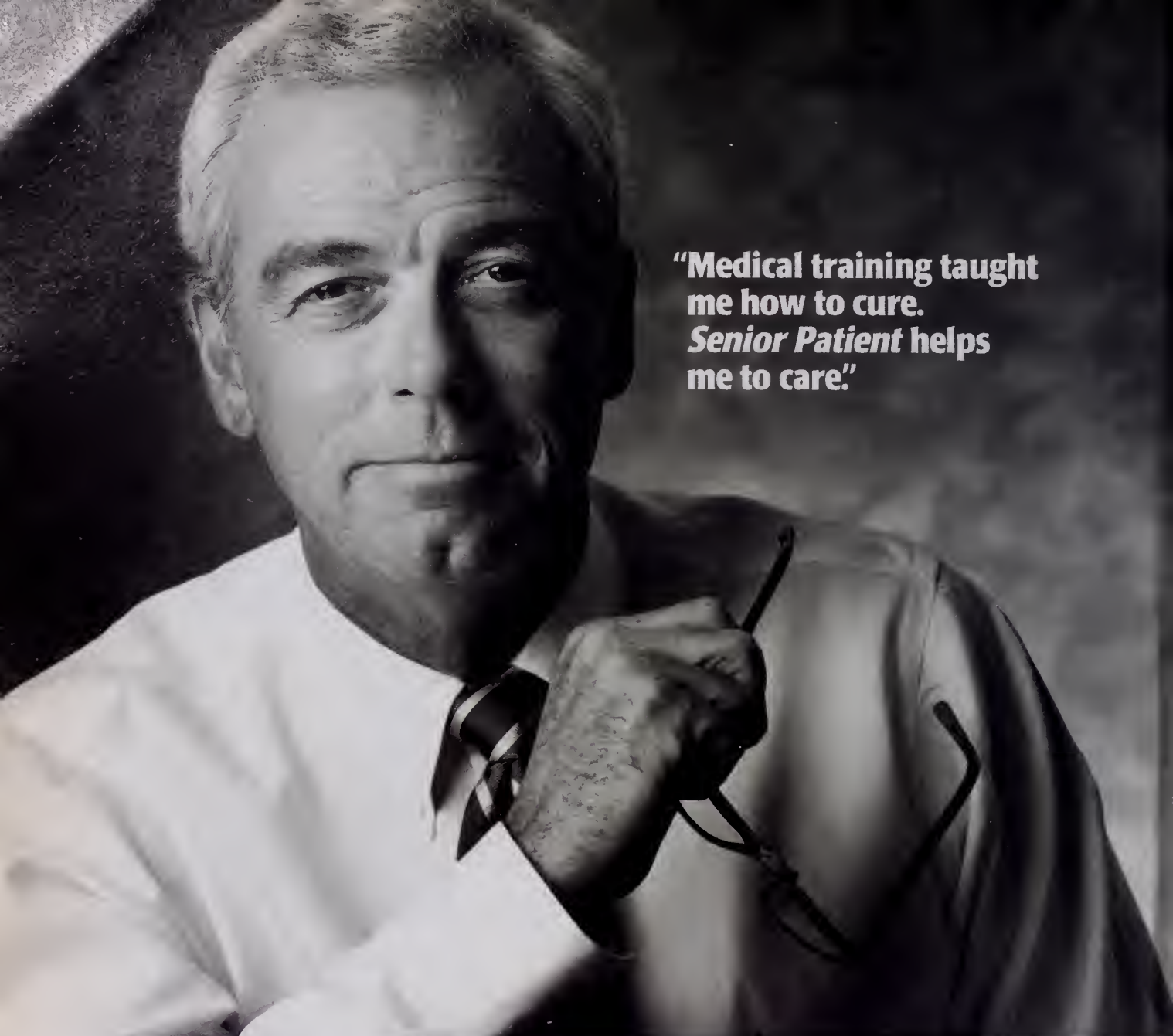


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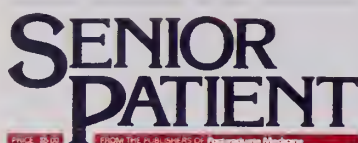


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me to care."**



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patient in and out of
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without hurting them
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Last words



Introducing a new "how to" publication for treating senior patients.

Senior Patient provides practical information designed to help you manage the care of your senior patients.

Its fresh approach in medical journalism presents short, easy-to-read, original articles on a broad range of subjects including emotions and coping, family relationships, death and dying, sleep disorders, community services, relations with institutions, and financial problems and their relation to health.

Each issue also offers "Pearls" from the personal experiences of other physicians, "Quick Currents" about what is happening in legislation relating to senior care, and an "Open Forum" in which readers can react and interact.

It's a concise, informative, "how to" approach in caring.





Savings?

By Donavin A. Baumgartner, Jr., MD
President of the OSMA

How many times during the past few years have we seen loudly proclaimed "savings" reported both in advertising as well as news articles discussing various new health-care schemes? It often seems daily. "So-and-so-plan saves \$300,000 for subscribers in only two months!", "Our careful review process is estimated to result in millions of savings over the next year." The claims go on and on. I feel certain that the desired result of increased subscriber enrollment must result.

But how much light of day will these claims tolerate? If we examine closely the majority of such "savings" we find some interesting massaging of data on one hand and clear evidence of deferred costs on the other. When one major third-party payer not too long ago broadcast widely that its new plan of preadmission screening had saved a million or so, they failed to provide the data on which such claims were based. When, in fact, the process of the trial period was examined, it was found that a curious method had been utilized, one which any health-care professional could have

indicated was bound to result in figures that would allow the impression of savings. The process worked as follows: When a patient was scheduled for admission, one of the company clerks would contact the attending physician and ask the estimate of number of days required for the stay. At this point, Dr. X, wishing to be conservative and realizing that a short estimate might cause problems for the patient as well as the physician, would naturally estimate on the high side. Thus a cholecystectomy patient that might be expected to stay from three to five days would be estimated by the surgeon at seven or eight. Armed with these estimates, the plan then authorized a stay of five days, a savings of two to three days in hospital costs. With each admission, these savings grew and were then totaled for the trial period with the resultant announcement that the pilot plan had been hugely successful and had saved this mythical and totally conjectural massive expenditure. All the public saw was that the plan certainly was cutting out the fat and putting it to all those

greedy hospitals and doctors.

Another form of highly touted "savings" had been the delay of surgery that in past times would have been carried out on an elective basis. Therefore if a plan encourages conservative (i.e. no) treatment for gallstones or hernias, one will see gross savings result. Recent articles have begun to appear that raise serious questions about the long-term effects and suggest that what is saved today may well cost many times over at a later point in time. Thus we see a report showing that the elective cholecystectomy rate has been dropping nationwide. At the same time, however, the number of patients with complicated and more serious biliary surgery has been steadily increasing. Coincidence? I think not! As more patients are treated medically to control "minor" symptoms and surgery is delayed, these patients are aging. When their disease process worsens with passage of time, they are less able to withstand the effects and the complications are more serious. The article goes on to point out

continued on page 708

PROFESSIONAL LIABILITY INSURANCE CO



In ten years your malpractice carrier may be just a memory.

Unless it's Medical Protective.

As you consider professional liability insurance, consider this. The coverages stated in the policy are basically a promise — a promise to be here when needed regardless of legal climate or economic conditions. A company's ability to keep this promise is critical because your financial security may depend on it. Unfortunately, too many firms are now finding the task impossible.

Analyze your liability insurance options carefully just as you would any important investment. Go beyond the agent and the policy to the company that

stands behind both. How long has it been in operation? Has it weathered some of the tough times? Will it be there for you when you need help?

The Medical Protective Company pioneered professional liability coverage before the turn of the century and has served doctors exclusively ever since. Over 500,000 of them. Through good times and bad. We'll be here when you need us.

Contact The Medical Protective Company through one of our general agents. History shows we keep our promises.

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The Usual Geriatric Euphemisms (Youngstown-Variants)

By Emil S. Dickstein, MD

“‘A home, well I guessed it’
Sighed old Grandma Ruth,
“But since you’ve confessed it,
Come now, tell the truth,

The name of this palace
Is it Ron Joy Spring Hills?”
(The old lady carped with some malice)
“Perhaps ‘Urine Smells’?”

“Little Forest Med Center,
Sleighbell Home for the Aged —
Should be ‘Puzzled Dementer’
Or ‘Cells for the Caged.’

Rolling Acres could be fakers,
Camelot Arm might mean harm,
And they’re all savings-takers,”
Thus she began to alarm.

“Sweet Diamondhead Village
Or Park Vista Hills,
My possessions they’ll pillage,
They ring up big bills,

Oh what a sad day!” —
With increasing outrage —
Quick I thought what to say
To these ripe with old age.



continued on page 707

IMAGINE A MACHINE THAT CAN DO THIS TO RENAL CALCULI

We're proud to announce the introduction of Extracorporeal Shock Wave Lithotripsy as a new feature of our kidney stone treatment program. This new device makes it possible to pulverize and eliminate kidney stones without invasive surgery. Now you have the opportunity to participate in this state-of-the-art procedure at CAMC's High Tech Center here in Charleston, West Virginia.

The Lithotripter uses shock waves to bombard kidney stones into sand-like particles inside the body. The residue is then easily passed. Although the theory behind Lithotripsy is simple, the process is precise. The stone is pinpointed inside the body with fluoroscopy and shock wave firing is synchronized with the patient's heartbeat by electrocardiogram. Usually, the entire process takes about an hour.

As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

We're encouraging all area urologists to apply for privileges in Extracorporeal Shock Wave Lithotripsy. We invite you to visit CAMC and see the lithotripter in action. Come and learn about this revolutionary therapy. We will happily provide you with a brochure for your use as well as brochures for your patients.

For your brochures or other information about Lithotripsy and our kidney stone treatment program, call CAMC: in West Virginia at 1-800-654-0159; from out of state, call 304-340-7315.

CAMC

Charleston Area Medical Center
We Care For West Virginia

LETTERS TO THE EDITOR

AIDS in Ohio

To the Editor:

I applaud your comprehensive and informative special May issue on AIDS in Ohio.

However, I would like to correct an error in your description of the new Medicaid AIDS waiver which appears in two places in the series: once in the boxed article entitled "The CAH Changeling" about the Avalon home, and again in the article entitled "Where Will All the Patients Go?" under "Money Needs, Money Worries."

There is one waiver, the Home and Community Based Service

(HCBS) Waiver II, known as the AIDS waiver. The waiver has very specific eligibility requirements: a diagnosis of AIDS or ARC, required ICF or SNF level of care, a hospital discharge directly into the Waiver Program, and a noninstitutionalized setting or a licensed community alternative home with required services that cannot otherwise be met in the community. In addition, the cost of covered services must be equal to or less than the federally approved cost cap established by ODHS.

To be eligible for the AIDS waiver, a person must also be financially eligible for Medicaid by one of three standards: income and resource less than the Medicaid standard, medical expenses great enough to reduce income to the Medicaid standard (spend-down) or income less than the special needs income of \$1,062/month.

The services available under the HCBS Waiver II are in addition to the regular Medicaid-covered services and only include: adult day care, case management, homemaker, personal care, respite care, some adaptive and assistive equipment, home-delivered meals, some medical supplies, nutritional consultation, respiratory therapy, social work/counseling and transportation.

For more information about the HCBS Waiver II program, please contact Carol Lynne Yaretts, RN, AIDS Waiver Program Administrator, Bureau of Community Services, 30 E. Broad St., 31st Floor, Columbus, OH 43266-0423, (614) 466-6742.

Sincerely,
Paul Offner
Deputy Director for Benefits Administration
Columbus

Geriatric Euphemisms . . . continued

"Granny, please show more gumption,
We ought all hoist a banner
For Our Lady Assumption
Or for Heritage Manor,

Ashley Place — fine showcase,
Westwood Arms has such charms,
And Maplecrest Care
Is a home with such flair!

For the hapless bedwetter
Whose family's been cursing,
Omni Manor's much better
Or Austin Woods Nursing.

At Colonial Manor
Or Edgewater Hills,
Each owns a CAT scanner,
Helps with overdue bills.

Just go with more grace,
It's not all Mickey Mouse,
You'll enjoy Glenn View Place,
Or Gillette's Country House!"

"You can't really disguise it,
My final repose,
For however one eyes it,
A rose is a rose.

Pick whatever the name
Still that rose sweetly smells,
And this old age home name game
Smells too! Oh, hell's bells!

Euphemisms (per Freud
Words hypocritically bent):
One just *tries* to avoid
What we all *know* we meant.

What we'd like to occur,
What old folks want to see,
That all really prefer —
Good old plain honesty.

We all know we will die,
For the old, bad things hover,
But there's no reason to lie
There's no reason to cover.

What will be, yes will be,
One accepts as we must,
But listen hard now to me,
Phony names are a bust!"

The OSMA Journal welcomes letters from its readers. Please address all letters to: Executive Editor, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824. Letters may be edited to meet space requirements.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine or the Ohio State Medical Association.

Emil S. Dickstein is an associate professor of medicine at NEOUCOM, and director of a long-term care unit in Youngstown.

COLLEAGUES

JAMES STEWART, MD, Middletown, has been installed as the president of the Ohio Urological Association . . . **CHARLES CHESANOW, DO**, Cleveland, has been appointed acting director of the eating disorders program at Harding Hospital . . . **LARRY J. COPELAND, MD**, Columbus, has been named director of the division of gynecologic oncology at Ohio State University Hospitals . . . **SPENCER ANDERSON, MD**, Parma, has been appointed cancer liaison physician for the next three years at Parma Community General Hospital . . . **WILLIAM K. SCHUBERT, MD**, Cincinnati, has been elected chairman of the Greater Cincinnati Hospital Council Board of Trustees . . . **HENRY R. HEIMLICH, MD**, Cincinnati, developer of the Heimlich maneuver, has been depicted in a painting honoring famous Cincinnatians . . . **WILLIAM H. PORTERFIELD, MD**, Columbus, has been re-elected chairman of Physicians Health Plan Corp. and chairman of the PHP of Ohio Board . . . Wadsworth-Rittman Hospital recently honored three of its physicians: **ROLAND BURELLI, MD**, Rittman, **ARIS FRANKLIN, MD**, Akron, and **MYRL NAFZIGER, MD**, Wadsworth, for the more than 30 years of service each has given the hospital . . . **CARIN OLSON, MD**, Shaker Heights, has been named this year's recipient of the Fishbein Fellow in

Medical Journalism by the *Journal of the American Medical Association*. The award is named for a former editor of the *Journal* . . . **RONALD FEGELMAN, MD**, Cincinnati, has received the William A. Friedlander Award from Jewish Hospital for his achievements in medicine . . . **JACK H. MEDALIE, MD**, Cleveland, director of the department of family medicine at Case Western Reserve University School of Medicine, has been named the sixth winner of the Maurice Saltzman Award by Mt. Sinai Medical Center . . . **CASS CULLIS, MD**, Troy, has been re-elected chairman of the American Heart Association's Miami Valley Heart Chapter . . . **GEARY M. EICHER, JR., MD**, Steubenville, has been named president of the Ohio State Coroners' Association . . . **DAVID L. WIRTZ, MD**, Newport, has been re-elected president of the Washington County Medical Society. Other elected officers are **GREGORY B. KRIVCHENIA, II, MD**, Marietta, vice president, and **DENNIS P. MLOT, MD**, Marietta, secretary-treasurer . . . **W. DAVID DAWDY, MD**, Westerville, has been elected president of Children's Hospital's medical staff for 1988 . . . **CHARLES CASTO, MD**, Stow, has received the annual Doug Dieken Award for Courage. The award, presented by retired Cleveland Brown Doug Dieken, honors Dr. Casto's exceptional courage, commitment and

contribution in the mental health area . . . **JAMES G. DILLER, MD**, Toledo, has been inducted as a member of the American College of Physician Executives . . . **RICHARD DIX, MD**, Akron, has been named one of four principal investigators on a multi-million dollar grant to study the links between the AIDS virus, herpes viruses and neurological diseases . . . **WILLIAM RUNDELL, JR., MD**, Dayton, has been elected chief of staff at Miami Valley Hospital . . . **JEROME M. RINI, MD**, Portsmouth, has been elected to a three-year term as treasurer, Ohio Chapter, American College of Surgeons . . . **EDWARD T. SCHIRACK, MD**, Canton, received an outstanding faculty award during commencement exercises held in June at the Ohio University College of Osteopathic Medicine. The award is given to physicians who have demonstrated outstanding interest in students and teaching and who have involved students in all aspects of patient care . . . **PATRICIA A. CHAMBLISS**, Shaker Heights, and **JAMES E. FLEMING, JR.**, Cleveland, both third-year medical students at Case Western Reserve University, have both received a 1988 Commonwealth Fund Medical Fellowship from the National Medical Fellowships, Inc. The program provides gifted minority medical students with biomedical research opportunities.

Savings . . . continued

the costs of these more complicated cases are far greater than the "routine" cases. This appears to be merely the tip of the iceberg. A recent article compared the nutritional status of patients undergoing head and neck surgery before and after the DRG system, and to no one's surprise found that the status of such patients was worse after the DRGs. Complication scores were *over two times higher* after DRGs.

As most physicians predicted, the continued push to shorten hospital stays has seen two side effects. The initial decreases are being reversed as the percentage of those admitted now are showing a much increased degree of severity. The intensity of care has also meant that the drop in length of stay does not translate into savings per case. In the greater Cleveland area, the average number of days

dropped 18 percent from 1982 to 1987. Length of stay declined to an average of 7.5 days compared to 9.2 days five years before, but with no actual significant decrease in cost.

One gets an even more clear picture of all these savings by tracking the premiums charged by the very companies claiming the largest amount saved. Curiously, none have reduced their premiums and yearly ask for higher rates. None advertise the numbers of added employees both at low- and high-level income that have been added to effect these savings or how much these added individuals increase the rates.

No one has been able to get a handle on the added costs to hospitals of requiring special new staff to handle the paperwork, phone calls and other red tape necessary to conform to all of the

rules and regulations designed to save money. Does anyone seriously think that hospitals and physicians' offices faced with added help to confront these demands will not reluctantly raise fees?

Beware when you read of savings in health care. We have sadly learned that income tax reform respectably translates into increased taxes for all concerned. We may well find that cost savings in health care translate into increased costs.

Recently a full-page ad by one of the new health plans proclaimed "We are in business for your health." An individual with insight pinned up the ad in the physicians' lounge but carefully penciled in the added words "care dollar." Perhaps that says it all. **OSMA**

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*Phillip H. Fisher, M.D.
Family Practice*

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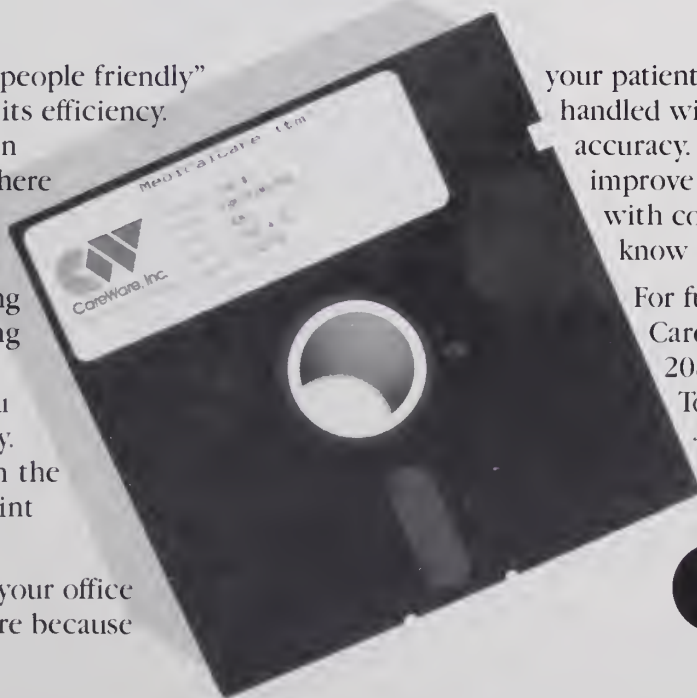
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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

Prescription drug abuse on the rise

Physicians can expect to see an increase in the abuse of prescription drugs if current trends continue, says Robert E. McAfee, MD. In a recent address to the AMA's National Invitational PADS Conference, Dr. McAfee outlined five reasons why addicts may turn to prescription, rather than illicit, drugs:

- Fear of AIDS. More and more users, he says, are forsaking injectable drugs such as heroin in favor of oral prescription drugs in order to cut down the risk of contracting the fatal disease.
- Mandatory urine testing in the workplace. If an employee is using a drug prescribed by a physician, Dr. McAfee explains, it is much less likely that he or she will incur negative consequences for a positive test.
- Sophistication of drug abusers. As users become more knowledgeable, he says, they realize that pharmaceuticals are more predictable in terms of purity, potency, and onset and duration of effect.
- Fear of incarceration. The fact that defrauding a physician is only a misdemeanor, whereas trafficking illicit drugs is a felony offense, may convince some abusers to choose prescription drugs — and the lowered risk of retaliation.
- Economic incentives. Prescription drugs may carry more allure, Dr. McAfee says, because many are reimbursable through state medical assistance



programs and/or Medicaid. Street drugs, on the other hand, are obtained only with cash. Concludes Dr. McAfee: "These five factors show us that the street market will continue to place high value on pharmaceutical products which have established, widespread and legitimate use in America's health-care system. Thus, we can be certain that the problem of prescription drug abuse will not go away."

Physician supply . . . and the predictions continue

Attempting to predict the future population of physicians in this country has proven to be about as conclusive as guessing the future population of a two-rabbit hutch — but it doesn't seem to prevent groups from attempting it.

The most recent prediction comes from the AMA's Center for Health Policy Research, which has issued a report entitled "Physician Supply and Utilization: Trends and Projections." The report projects that the active physician population in the U.S. will increase from 519,400 in 1986 to 633,200 by the year 2000.

Female physicians will increase their ranks by 91.9% by the year 2000, compared with just a 9.2% increase projected for their male counterparts. There were 79,606 female physicians and 439,805 males in 1986. This is expected to increase to 152,700 female and 480,400 male physicians by the year 2000. Although women made up only 15.3% of physicians' ranks in 1986, they will account for 24.1% by the year 2000, the report continues.

General internal medicine is projected to remain the most heavily populated specialty by the year 2000. Growing at a rate of 28.7%, this specialty is projected to include 92,500 physicians in 2000. Given this scenario, general internists will make up 14.6% of the physician population in 2000, compared with 13.8% in 1986 — at least until the next prediction comes along.

Psychiatry's present — and future — improvements

The revised issue of Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III-R) is fine-tuning diagnostic criteria for psychiatrists increasing the clarity of hundreds of psychiatric disorders, says Robert L. Spitzer, MD, a professor of psychiatry at Columbia University and chairman for the more than 200 psychiatrists and psychologists involved in the revision.

A number of new categories have been included in the revised manual including a section on sleep disorders.

"This will help bring sleep medicine into the mainstream of psychiatry," says Dr. Spitzer. "Ultimately, it will mean that more psychiatrists will be trained to recognize and treat sleep disorders."

A similar evolution has already taken place with panic disorders, he continues. This diagnosis, which first appeared in DSM-III, was a significant step toward helping people who suffered repeated unprovoked attacks of terror but didn't know what the problem was. Before DSM-III, victims were variously treated for diagnoses that ranged from schizophrenia to heart attack, but they were rarely helped.

One challenge for psychiatry today is to communicate basic information about common mental disorders, like panic disorders, to family physicians and internists — the doctors people see most often. These doctors need to know how to recognize and treat such problems and when to refer patients to an expert, says Dr. Spitzer. The need is urgent, psychiatrists say, because at present, 80 percent of people with psychiatric problems never get appropriate help.

Another challenge facing

psychiatry is to find ways to differentiate disease subgroups — such as types of depression — that may respond to different medications or other treatment modes.

As it edges toward the 21st century, psychiatry will doubtless add new diagnostic techniques to the present ones of observation and interview. A group at Cornell Medical Center in New York City, for example, is working on a blood test that may identify persons at high risk for suicide.

Other researchers are using various methods of scanning the brain to seek physical traits that will help differentiate one disorder from another. Some of these technologies produce images of the brain's internal anatomy; others show regions of higher or lower metabolism or blood flow.

In this same vein, scientists are coming closer each day to

identifying specific genes for various types of mental illness. Families have already been found with distinctive patterns of inheritance of depression, and specific genetic features related to Alzheimer's disease have been identified. Such studies have profound implications, not only for diagnosis and treatment, but for prevention.

Will the diagnostic handbook one day include a host of physical tests in addition to its lists of symptoms? "It's a little early, but I think it's going to happen eventually," says Herbert Pardes, MD, professor and chairman of psychiatry at Columbia University and director of the New York State Psychiatric Institute in New York City. "These may be poured right into DSM and might even radicalize it," he adds. "We'd like to have these tests and we're getting closer all the time."



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OHIO MEDI-SCENE

Lung patients on vacation . . . the increase in rheumatic fever . . . rural teen pregnancy . . . Cleveland Academy trauma guidelines . . . OSMGA tournament . . .

Lung patients take to the high seas

At first mention, a Caribbean cruise in the middle of May doesn't sound too unusual. Oh, it might evoke a twinge or two of envy among your co-workers, but it would hardly raise any eyebrows. After all, thousands of people flock every year to points south to enjoy the warm climes and tranquil, inviting waters.

But when you're oxygen-dependent — a victim of chronic lung disease — a cruise to the Caribbean, or anywhere for that matter, is much more than a welcome respite from work. It's confirmation that you're capable of doing just about anything a so-called "normal" person can do — including sailing the high seas.

On a warm day last spring, that's exactly what Jennifer Stewart did. With the support of the Pulmonary Treatment Center at University Hospitals of Cleveland and the Linde Medical Home Care Company, she and about 20 other lung patients from across the country were able to take advantage of a Caribbean cruise. For many of the patients, it would prove to be the vacation of a lifetime.



OHIO MEDI-SCENE

The high seas . . . *continued*

"I've been away from home before," says Stewart, 28, of Chesterland, "but this was the farthest I've ever been." Stewart, who was diagnosed as having Hodgkin's disease about 15 years ago, eventually began receiving radiation to combat the disease. Ironically, the same therapy that probably saved her life caused lung problems serious enough that she received a tracheotomy about a year and a half ago and now she depends on a ventilator at night.

Nonetheless, she says, "The whole trip was great. The weather was good, too. It was hot, but not like it is here. I could actually breathe easier."

Like Stewart, Barbara Gothe, MD, a pulmonary internist at University Hospitals, would call the trip a success. "I think it's a great thing to do," says Dr. Gothe, who accompanied the group. "(The patients) can get out safely, have a good time, take pictures and tell their friends about it."

While it may have been the first vacation for many of the patients, it was old hat for University Hospitals and Linde, which have sponsored two previous excursions. While University Hospitals arranges for the cruise, Linde takes care of transporting the nearly four tons of necessary medical equipment. Both, however, are responsible for recruiting patients for the cruise — namely, through mailings and word of mouth.

"This was the third cruise," Dr. Gothe notes, "so it's already well-established. Most of the bugs have been worked out."

Still, she says, weeks of organization and consideration go into planning such a tour. "You have to plan for a cruise for people who are not normal. You can't have (sidetrips) where there's a lot of hilly terrain. Everything has to be easily accessible."

A respiratory therapist and a physical therapist from University Hospitals also accompanied the group, but Dr. Gothe says the patients required very little assistance. "The patients had had episodes in their past, but by (the time of the cruise) they were stable," she explains. "The staff didn't really have to do anything because the patients are very knowledgeable about their condition and what their medications can do."

Originally planned to accommodate about 100 patients,

this year's tour only included about 20. "We would've liked to have had that many (100)," Dr. Gothe says, but a snafu with the U.S. Coast Guard almost necessitated canceling the trip altogether. It seems that when the Guard learned that liquid oxygen — an absolute must for the patients — would be taken on board, it balked. Because the program has never experienced such a problem before, University Hospitals suspects that a change in Guard personnel may have been at the root of the misunderstanding.

"It was uncertain whether or not the cruise would take place with the regulations, so people were reluctant to sign up," Dr. Gothe says, adding that, "The problem is that liquid oxygen is flammable and there are certain safety precautions you have to take. They were worried about having it on board because they didn't have a set policy about it."

Fortunately, clearance was given, and on May 8 the group set sail for a seven-day cruise to the Cayman Islands, Cozumel, Jamaica and Haiti.

"I really liked Haiti and Jamaica," Stewart says, recalling the trip, "especially the rain forest in Jamaica."

"I couldn't go swimming," she continues, "but you could do things like go shopping, and they always had a bus to pick you up."

Dr. Gothe elaborates further. "They couldn't do very much, but they know this. We mostly walked around, went on tours and did some sightseeing." There were also



planned physical activities on board the ship, such as swimming and shuffleboard, for those who were able to participate. For most patients, though, there were wheelchair exercises, upper body exercises and walking sessions. A physical therapist also conducted one-on-one aquatic exercises with some patients in the ship's pool. Such activity was mainly restricted to the ship, Dr. Gothe explains, so that if needed, medical attention could be quickly summoned.

While no serious emergencies arose, University Hospitals workers were always on guard. "They can get pneumonia, fluid retention, more shortness of breath, and their gas exchange will become impaired," Dr. Gothe says, citing

the numerous complications chronic lung patients may experience.

"Patients with this degree of disease can get sick quickly," she continues. "They can get an infection which can quickly become life-threatening."

Stewart concurs. "The only thing that could've come up was an infection — I get infections all the time — but they had antibiotics so I wasn't too worried."

Fortunately, Dr. Gothe adds, "There was a whole hospital on the ship in case we had a real emergency, whereas on the islands, there are no facilities."

There was, however, no need to test the staff's ability to cope with

a crisis. "We were lucky. Nobody got ill," Dr. Gothe says. "There was some anxiety, but it was never allowed to grow."

Overall, Dr. Gothe says, the trip was an enormous success.

"Things went real smooth. (Pulling) something like this off requires a certain attitude and commitment from the staff. In order to be good, the effort never shows."

And that dedication, she says, made for a most memorable trip.

"One day you're in intensive care, the next day you're on a cruise.

That's the way it should be, don't you think?" — *Michelle J. Carlson*

On the rheumatic fever trail

It's something of a mystery. It's left a trail of evidence through Salt Lake City, Pittsburgh, Akron and Columbus, but the evidence is mostly circumstantial. Investigators are on the case, but no cause has been unearthed, and a verdict could be a long time in the making.

The culprit is rheumatic fever, which has made a perplexing resurgence in several hot spots around the country. While rheumatic fever has never completely disappeared from the doctor's office, its incidence has been fairly low for about 10 years, according to Blaise Congeni, MD, Director of Infectious Diseases at Children's Hospital Medical Center in Akron.

In 1987, physicians at Children's began to observe a noticeable increase in the number of rheumatic fever cases they were treating. There would normally be one or two cases per year, compared to the 20 to 30 cases we saw in the past several years, Dr.



Congenani explains.

"Obviously that seemed rather high to us, but we didn't realize just how marked the increase was until we compared it to figures for the last 10 years," he says.

Dr. Congeni and others then launched a study to discover more about the outbreak. The researchers reported that more than 40 patients had been treated for rheumatic fever at Children's from January 1986 to August 1987 — almost 10 times the normal number of cases.

Among the study's other findings, which were published in the *Journal of Pediatrics*, were that: (1) there was a marked increase in rheumatic fever in

several widely separated areas in the country, with several areas in Ohio being particularly hard-hit; (2) the disease was the same as it was in the past; and (3) the disease was affecting children in non-urban settings who had adequate access to medical care, rather than inner-city children, whom the researchers suspected would be more susceptible.

Similar reports were popping up in other areas of the country as well, with some of the first reports of an outbreak coming from Salt Lake City, Dr. Congeni notes.

Dr. Congeni and other researchers then studied a group of 400 schoolchildren from Summit County to determine the incidence of strep throat. They found that 45 percent of the children showed symptoms of strep, a much higher percentage than expected. (Because strep and rheumatic fever typically affect those age 3 to 18, the study focused on children.) These results were reported last fall at an Infectious Disease Conference in

OHIO MEDI-SCENE

Rheumatic fever . . . *continued*

New York City.

The study also indicated that many physicians are diagnosing strep throat differently than in the past. Approximately 30 percent are using strep kits rather than throat cultures, says Dr. Congeni, a method that is quicker, but not as efficient.

Dr. Congeni is hopeful that recent articles and studies will increase physician awareness about the outbreak. Because untreated or undiagnosed strep may be the prime suspect in the occurrence of rheumatic fever, the physician's ability to diagnose strep is essential in curbing the disease's spread, he points out. He recommends checking for strep in all patients who come in to the office with sore throats and confirming strep kits results with the more reliable throat cultures.

In addition, physicians must emphasize to parents the importance of adhering to the prescribed medical therapy, he adds.

Akron researchers are collaborating with researchers nationwide, including an internationally regarded strep expert from the University of Minnesota Medical School, who is currently examining throat cultures from Children's and other hospitals.

Overall conclusions about the outbreak are still sketchy. However, researchers do suspect that these cases are not triggered by a single strain of strep throat, but are caused by a variety of sero types.

Some reports have indicated that

the new strain of rheumatic fever attacks children's heart valves more quickly and severely than past strains. But Dr. Congeni suggests that the increased recognition of heart valve damage may be due to medicine's improved diagnostic tools, rather than to a new, more dangerous strain of rheumatic fever.

Because the number of strep and rheumatic fever cases falls off in the summer months, Children's researchers — like any good detectives — are lying low only temporarily, compiling, refining

and comparing their notes.

"What we have to do is try and look at the situation again (next winter) to determine if the high colonization rate is still present. We're going to continue to investigate the reasons for the outbreak," he says, although — like in most medical ventures — much depends on funding.

And while many of the clues behind the outbreak remain clouded in mystery, Dr. Congeni assures, "We're watching the situation closely." — *Deborah Athy*

Keeping rural teen pregnancy under control

Marion, Ohio is a pleasant little community, located just to the north of Columbus, about an hour's drive away. It's the type of all-American town that makes you think, "What a nice place to raise a family."

And therein lies a tale — a familiar tale, about teen-age pregnancy.

In the late 1970s, over 20 percent of all pregnancies occurring in Marion were teen-age pregnancies and, at that time, that percentage exceeded both the state and national average. That the problem continues today is a reflection of society. That the percentage of teen-age pregnancy in Marion has decreased dramatically in recent years is a reflection of something else entirely.

When James Bazzoli, MD, a Marion obstetrician, describes the Marion Adolescent Pregnancy Program (MAPP), a plan that he conceptualized, developed and initiated in 1979, he speaks of a labor of love, but you can't escape the note of pride in his voice as he tells you about it. Since MAPP began its multi-pronged education and counseling services, teen-age births in Marion County have dropped from a high of 246 in 1976 to its lowest figure yet, 151, in 1987. The program's success recently brought it to the attention of the American Medical Association, which asked Dr. Bazzoli and MAPP Executive Director Jody Demo-Hodgins to present it as a model program at the AMA's national congress on adolescent health this past spring.



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OHIO MEDI-SCENE

Teen-age pregnancy . . . *continued*

Still, Dr. Bazzoli is not one to rest on laurels. In fact, you get the impression Dr. Bazzoli isn't one to rest much at all. He's the type of individual who, if you were in politics, you would want to serve as your campaign manager. He could get you elected single-handedly.

"Of course it's easier to roll over and die," says Dr. Bazzoli, explaining his ongoing promotion of MAPP, "but you can't give up on the problem."

The problem, as he sees it, is

not just the "kids-having-kids" syndrome, but a community's tendency to ignore the situation — as though it just didn't exist.

When he began structuring the groundwork for MAPP, Dr. Bazzoli found that this denial presented his first obstacle.

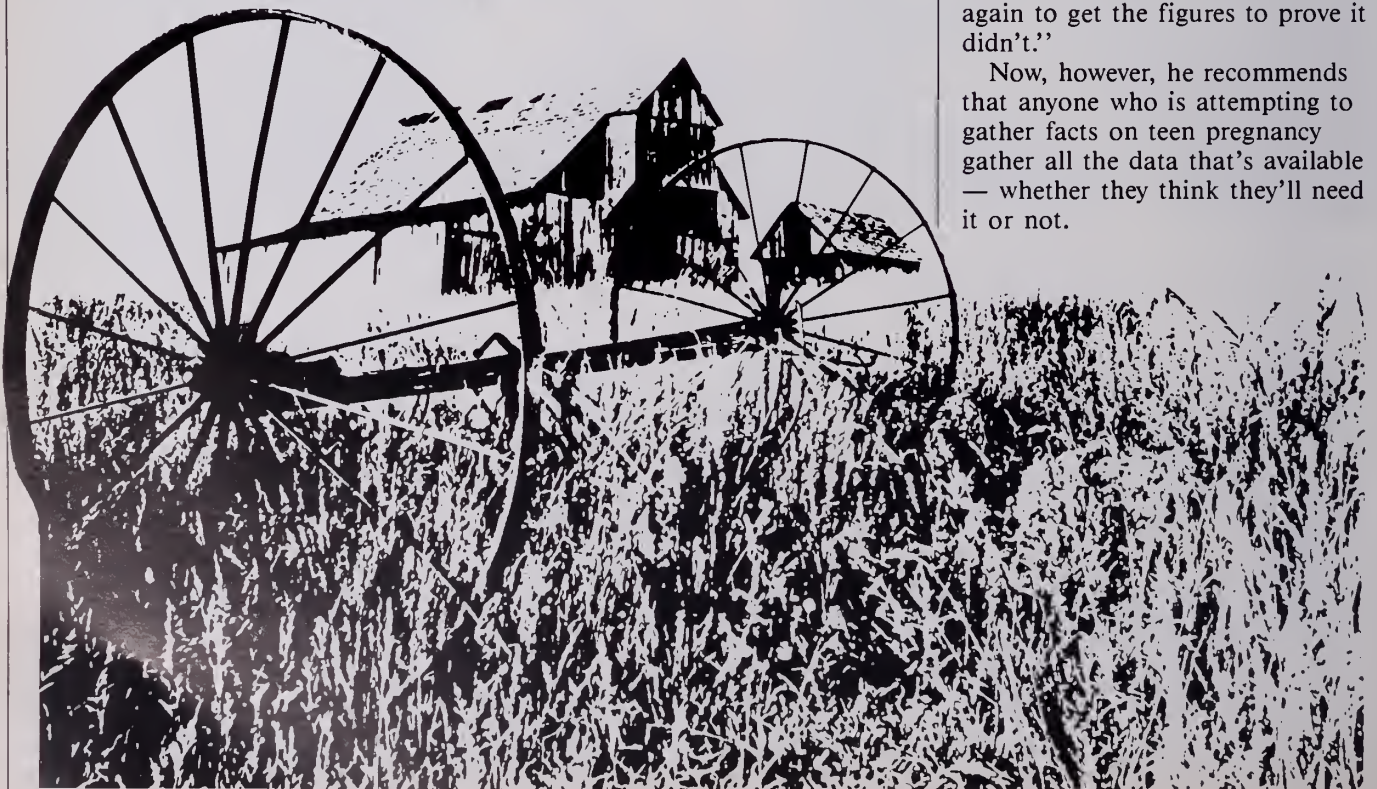
"The community, here, felt that teen pregnancy was a big-city problem, that it wasn't happening here," he says.

So he dug up the facts, the local data, and proved that it *was* happening — and in astonishing percentages.

"Then they said that it (teen pregnancy) was a minority problem," Dr. Bazzoli recalls. He went back and gathered more statistics to show them that it wasn't.

"Then they said it was an out-of-staters' problem, that it was only happening to those people who had moved here from other areas, like West Virginia and Kentucky," Dr. Bazzoli laughs. "I didn't think a parent's home state had anything to do with teen pregnancy when I was gathering my data, so I had to go back again to get the figures to prove it didn't."

Now, however, he recommends that anyone who is attempting to gather facts on teen pregnancy gather all the data that's available — whether they think they'll need it or not.



"You cannot have enough local data," he comments, adding that using other people's data, in addition to what you may find, helps eliminate any suspicions of bias that may be forming.

Even then, however, what you find may not be enough.

"I'm still in a position where I constantly have to prove there's a problem," says Dr. Bazzoli.

So, he goes back and runs through the scenarios again — this time for a new crop of school principals — or teachers — or parents — or kids. And every couple of months, like any savvy marketer, Dr. Bazzoli tries to generate some media attention in the subject — anything that will keep it fresh in the community's mind.

Last year, it was billboards carrying messages that read: "Teen Pregnancy — Do You Care?"; "She Should Be At School, But . . ."; and "Guys . . . The Other Half of the Teen Pregnancy Problem."

It made the community think. It made parents, and the teens themselves think.

"It made one local minister feel so guilty that he hadn't addressed the problem in his own church that he sent for material," says Dr. Bazzoli.

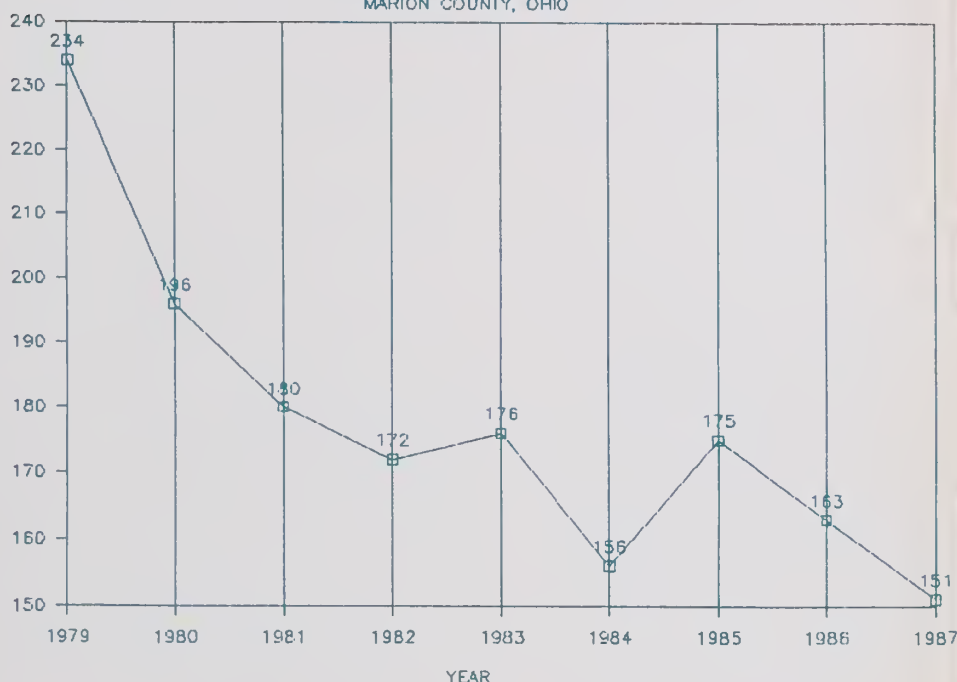
And MAPP was quick to respond with a packet from the hundreds of brochures and handouts, leaflets and lists they keep onhand. For MAPP is, if nothing else, an educational source on teen-age pregnancy for the community.

"The biggest advantage is that we have MAPP personnel located in two of the largest obstetrical practices in town," says Dr. Bazzoli. It facilitates that initial contact which most teens — if left to their own device — would most likely ignore.

Teens, after all, are not adults, Dr. Bazzoli is quick to remind you. They are not anxious to do what's best, but, instead, what's easiest.

TEENAGE BIRTHS

MARION COUNTY, OHIO



"When you're dealing with a teen-ager, you can tell them to do something 20 times, and they still won't do it," he says.

Repetition and follow-up are the keys, he stresses. So, too, is treating teens like kids — not adults.

"We see our teen patients earlier and more frequently than we do our adult patients," says Dr. Bazzoli. "Generally we see the teens about every two to three weeks."

If the teen is identified as a high-risk patient, MAPP will make serial visits to the home, making sure that the pills or prenatal vitamins are taken, and that the mom-to-be is eating nutritiously and following doctor's orders.

But if MAPP, from time to time, must assume the role of a nagging parent, it takes time, too, to assume the perspective of the teen.

"Sometimes, you have to think like a 13- or 14-year-old if you want to apply an adult solution to the kids," says Dr. Bazzoli.

For example, when no teen moms signed up for Lamaze classes, Dr. Bazzoli set about obtaining funding for the kids, knowing money was certainly an obstacle at this age. When that failed to produce results, however, he had to go back and think again — finally realizing that pregnant teen-agers were bound to feel uncomfortable in a group of older, married women. So, he set up a class for his teen patients only (and their significant others), and now sees an 80 to 90 percent compliance rate among his patients.

Prevention, however, is still the name of the game, as Dr. Bazzoli sees it — and it's a crusade he carries with him everywhere in Marion, into schools and churches, to community groups and to the media.

It's still a difficult game to win, he admits.

"Kids are sexually active in record numbers today, and they are getting active at younger and younger ages," Dr. Bazzoli claims.

OHIO MEDI-SCENE

Teen-age pregnancy . . . *continued*

Society, he says, is teaching them it's all right to be sexually active.

"TV is partly to blame," he continues, pointing out that "The Mickey Mouse Club" and "Leave It to Beaver" no longer constitute after-school programming for today's kids.

"Now they're more likely to catch reruns of 'Three's Company' or 'Dallas' — programs that ran later in the evening when they were on originally."

Now, however, the kids are

seeing it's OK to be a guy and live with two girls, that it's socially acceptable to jump from one bedroom to the next. The ironic thing is that while television is falling down on its duties to teach sexual morality, it's succeeding in teaching kids not to abuse drugs. The "Just Say No" campaign is apparently working.

"A poll in our local paper showed that 80 percent of teenagers in this area don't believe in drugs," says Dr. Bazzoli, "but an equally high percentage of them

do believe in sex before marriage."

So Dr. Bazzoli goes back and he paints the scenarios again — for the principals, for the teachers, for the parents and the kids. He talks to the churches, to the community groups.

And he looks, again, for media attention. — *Karen S. Edwards*

Cleveland Academy adopts trauma care guidelines

The National Research Council issued a White Paper 22 years ago, calling trauma "the neglected disease of modern society."

"Since then," writes John G. West, MD, and colleagues in a recent *JAMA* article which reported on a survey of state emergency medical services, "progress in implementing regional trauma systems has been disappointingly slow."

"The public clearly expects high-quality health care and has allowed the medical community great leeway in developing appropriate systems," the authors conclude. "Failure to implement a national network of comprehensive regional trauma systems could result in a backlash of public opinion that would open the door to outside

Dr. Bazzoli's guide to reducing teen pregnancy

1. Collect local data — from health departments, hospital records and the state department of health. Use national data, too, when you can.
2. Familiarize yourself with existing available services in your area, to know what's out there and whether or not you need to establish an agency of your own.
3. Heighten public and community awareness of the problem through the media.
4. Seek funding.
5. Start small but think big.
6. Use volunteers; seek the support of the medical community.
7. Take the program to the teens, and tailor the program to them.
8. Don't fail to treat teens as kids — and use repetition, repetition, repetition.
9. Gradually expand your services, adding parenting classes, Lamaze classes, career and education services.
10. Incorporate preventive and educational services into the program.
11. Continue to educate and enlighten the community about the problem — faces and names change, but the problem remains the same — kids having kids. Don't rest on your laurels! — *Karen S. Edwards*

Optimal care guidelines for treatment of trauma patients

control and regulation. We must aggressively pursue a solution to the trauma dilemma to avoid such intervention, and more importantly, to ensure the highest quality of care for our communities."

In the wake of the cautionary article, the Cleveland Academy of Medicine reports that guidelines for treatment of trauma patients have been adopted as policy by the Academy of Medicine of Cleveland. "Optimal Care Guidelines for Treatment of Trauma Patients" was developed to establish the medical community's position of commitment to the highest possible standard to trauma care in Cuyahoga County, reports Daniel W. van Heeckeren, MD, president.

The stated goal of the guidelines is to get the most seriously injured patients to optimal, definitive care in the shortest period of time. To accomplish this, the decision as to disposition of the patient must be made utilizing off-line and on-line medical direction; patients with multi-system or major trauma should be evaluated by a general surgeon, and severely injured patients should be transported to the most appropriate hospital within 30 minutes.

These guidelines are intended to be integrated with the contributions of non-physician trauma system participants, according to David Lehtinen, MD, chairman of the Academy's Trauma and Emergency Care committee, which initiated the guidelines. A community-wide organized trauma system must have the active participation and cooperation of all appropriate medical specialties, along with mayors, city managers, safety forces and hospital administrators, Lehtinen said.

The Academy's Trauma Care Guidelines follow:

1. The concept of always taking the severely injured patient to the nearest hospital is no longer acceptable.
2. All patients with multi-system or major trauma should be promptly evaluated by a general surgeon.
3. Surgeons who treat trauma patients must be highly qualified. Basic qualification for trauma care for any surgeon is Board-Certification in a surgical specialty. It is recognized that many boards require a practice period and that complete certification may take two to five years after completion of a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME). If an individual has not been certified five years after successful completion of an ACGME residency, that individual is unacceptable for inclusion in the trauma team. In some instances, American Board certification will not be possible when that individual has trained in a foreign program. Such an individual can be included when he or she has equivalent recognition by major professional organizations, as is common in his or her specialty (e.g., A.C.S.) The completion of ATLS* is an indication of commitment to trauma care. The surgeon who cares for trauma should be regularly involved in the care of injured patients and demonstrate continued education in trauma.
4. For an emergency physician dealing in trauma, Board-Certification in emergency medicine, or pediatrics for

those physicians staffing children's hospitals, is desirable and specific preparation for the care of the injured patient is essential. The completion of ATLS is an indication of a commitment to trauma care. The emergency physician should be regularly involved in the care of injured patients and demonstrate continued education in trauma.

5. Anesthesiologists and medical consultants should be appropriately Board-Certified. In addition to Board-Certification, anesthesiologists should have an awareness of the unique problems of trauma patients. It may be desirable for medical consultants regularly involved in trauma to have satisfactorily completed an ATLS course. The completion of ATLS is an indication of commitment to trauma care.
6. Severely injured patients should be transported to the most appropriate hospital within 30 minutes travel time.
 - A. Level I and Level II institutions should be staffed 24 hours a day by Board-Certified emergency physicians. Board-prepared emergency physicians in the process of certification are acceptable.
 - B. Level I hospitals should be staffed in-house 24 hours per day by a surgeon with privileges to perform any necessary surgery on multiple-trauma patients. An attending level trauma surgeon whose qualifications meet the criteria of the American College of Surgeons must be on-call and promptly available from inside or outside the hospital.
 - C. Level II hospitals should

*Advanced Trauma Life Support

OHIO MEDI-SCENE

Trauma guidelines . . . continued

ideally ensure that the trauma surgeon will be present in the emergency department at the time of the patient's arrival. When sufficient prior notification has not been possible, a qualified emergency physician (see section 6A) will immediately initiate evaluation and resuscitation. Definitive surgical care must be instituted by the trauma surgeon in a timely manner that is consistent with established standards.

- D. At Level I or Level II hospitals, the emergency department's initial management and resuscitation of the trauma victim must be under the supervision of an attending level physician who is physically present at the resuscitation. This attending may either be a qualified emergency physician (see section IIA1a) or an attending level trauma surgeon.
- E. If the most appropriate hospital is greater than 30 minutes away, the patient should be taken to the nearest hospital and all major injuries secondarily triaged to more appropriate facilities after initial stabilization. It is recommended that inter-hospital triage criteria be established by institutions who may not meet Level I

or Level II criteria for optimal care of the trauma victims.

Hospitals should ensure that trauma patients receive prompt definitive care or expeditious transfer to an appropriate hospital. An example of transfer guidelines are found on table 2 of Appendix F of the Hospital and Prehospital Resources for Optimal Care of the Injured Patient published by the American College of Surgeons, October 1986 (see attached).

7. Who makes the triage decisions?
- A. The principles by which the paramedic makes medical decisions are determined by off-line medical direction. The specifics of paramedic care, within the limits of the above principles, should be determined by on-line medical direction in communication with the paramedic on the scene. This applies to the care of all patients, whether ill or injured. Ideally, this shall apply to all EMTs performing an advanced life support function.
- B. The qualifications of physicians involved in on-line and off-line medical direction should be as stated by the Cuyahoga County EMS Advisory Board Resolution No.

EMS-86-06-03-E of April 1, 1986, entitled "Guidelines for the Qualifications, Responsibilities and Authority of Individuals and Institutions Providing Medical Direction of Emergency Medical Services" (see attached).

8. What indicators of trauma severity should guide triage decisions?
- A. The trauma score is only one factor which the on-line medical director must consider in the triage of the trauma patient. We endorse the Prehospital Index (attached) as an example of one acceptable scoring system which may be performed by EMTs.
- B. It is important to note that patients with PHI greater than eight have a 41 percent mortality. This signifies that each patient in this category should be transported to a facility optimally prepared to care for the patient.
- C. The goal is to get patients to optimal definitive care in the shortest period of time. With this in mind, all pre-hospital and hospital emergency medical services should have the procedure in place to effect the direct transfer of seriously ill or injured patients to the most appropriate facility. In any case, the decision as to the disposition of the patient must be made utilizing off-

line and on-line medical direction.

D. Given the goal of delivering patients to optimal definitive care in the shortest period of time, local factors which must be considered by on-line medical directions are listed as follows:

- 1) Ability of the hospital to respond with all of its resources in a timely and appropriate manner.
- 2) Ability of the local emergency department to absorb the patient or patients at that time.
- 3) Weather conditions which may affect the ability of helicopter and ground units to respond.
- 4) Number of victims.
- 5) Transport time to a hospital specializing in trauma care.
- 6) Availability of critical care transport.
- 7) All implications of taking a squad out of service for prolonged transport to a distant center.

E. How are they incorporated into decision-making?

- 1) The judgment is made by on-line medical direction, consistent with the principles established by off-line medical direction.

9. What should be the ongoing monitoring?

- A. A Trauma Coordinating Committee (TCC) should be formed containing representation from the Greater Cleveland Hospital Association, the Academy of Medicine and the Cuyahoga County EMS Advisory Board. The Academy of Medicine representation must be prepared to present the viewpoints of all physician participants in trauma care. The functions of the TCC should be as follows:
- 1) To set up criteria by

which trauma care may be monitored, both in hospitals which claim a special expertise in trauma and in those hospitals which do not claim this special expertise.

- 2) To provide the mechanism by which this monitoring will occur.
- 3) To provide for the timely dissemination to all appropriate caregivers of any information derived from the monitors which will assist in making patient triage and transfer decisions.

B. For the purposes of quality assessment and clinical decision-making, hospitals should maintain data on

their own trauma care.

10. The use of this document and principles of building a trauma system.

A. No community-wide trauma system can proceed without the active participation and cooperation of all involved medical specialties as well as non-physicians such as mayors, city managers, safety forces and hospital administrators.

B. This document is intended to be integrated with the contributions of other medical specialties and non-physician trauma system participants. The use of this document outside of this context would be contrary to the intent of its authors.

— Karen S. Edwards

Parsons, Thompson capture trophies at 63rd OSMGA tournament

One hundred thirty-five physicians, honorary members and guests competed in the 63rd Ohio State Medical Golfers Association Tournament on Friday, June 24, 1988, at the Marion Country Club, Marion, Ohio.

Low gross honors were won for the third time by Charles D. Parsons, MD, a urologist from Springfield, who shot an even-par 69. Dr. Parsons previously took low gross honors in 1983 and 1986. His name will be inscribed on the Richard P. Bell Trophy.

Charles L. Thompson, MD, of Lima, a family physician, took low net honors with a 62 (86-24 handicap). His name will be inscribed on the Dr. Ray Stephens Memorial Trophy.

Winner of the Dr. Carm Shames Memorial Award for Most Improved Golfer, Scratch, from 1987 to 1988, was Richard R. Hille, MD, of Marietta. Dr. Hille

chopped 20 strokes from his 1987 total. The Shames Award for Most Improved, Net, went to John F. Harley, MD, of Springfield. Dr. Harley's net score of 69 was 18 strokes lower than his 1987 total.

Winners in age flights were as follows:

Low Gross, Age 39 and Under —
David G. Monjot, MD,
Springfield (83)

Low Net, Age 39 and Under —
Michael E. Ruff, MD, Columbus
(68)

Low Gross, Age 49 and Under —
James E. Bagenstose, MD, Lima
(71)

Low Net, Age 49 and Under —
Richard B. Ogle, DO, Mt.
Vernon (63)

Low Gross, Age 59 and Under —
Bae Woo Park, MD, Barberton
(75)

Low Net, Age 59 and Under —
John T. Sweeney, MD, Mt.
Gilead (64)

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OSMGA tournament . . . *continued*

Low Gross, Age 69 and Under —
John C. Stahler, MD, Dayton
(78)

Low Net, Age 69 and Under —
Glenn O. Lease, MD, Dublin
(63)

Low Gross, Age 70 and Over —
Charles H. Buchert, MD,
Middletown (87)

Low Net, Age 70 and Over —
Clarence M. Gallagher, MD,
Columbus (71)

In special events competition, M. Albainy, MD, of Parma, placed his tee shot closest to the pin on No. 15. Herndon P. Harding, Jr., MD, of Worthington, hit the longest drive on No. 13.

Receiving special recognition as the first female physician ever to compete in the OSMGA Tournament was Kathy Lutter, MD. Dr. Lutter recently completed her residency training, and will be practicing Ob-Gyn this summer in Columbus.

During the awards banquet, OSMGA President David M. Bell, MD, paid tribute to Marion County Club General Manager Wolf Pearson and golf professional Ross Carley for their outstanding work with the event.

Several members of the Marion County Medical Auxiliary were recognized for outstanding work in registering the 135 golfers. Included were Doris Albernaz, Sharon Gale, Anne Heckendorm, Val Hedges, Barbara Jackson, Judy Knox, Linda Landefeld, Jeannie Lowe, Pam Miller, Pat



Kathy Lutter, MD, the first, but not last, woman player in the OSMGA tournament.

Pua, Nancy Sitterley and Margaret Winegarner.

Thanks to the tournament's sponsors, participants were treated to a golf clinic by PGA Touring Pro Chris Perry following competition. Perry warmed up for the clinic by playing in a foursome which included his father-in-law, K.K. Solacoff, MD, of Upper Sandusky; David R. Miller, MD, of Marion; and Donald E. Widman, MD, of Galion. The warm-up resulted in a 64 which set a new record for the Marion Country Club course.

The OSMGA is seeking to schedule the 1989 event at Westbrook Country Club in Mansfield, Ohio. — *Robert Clinger*

Medicine's biggest problem? Here's what the majority think . . .

In your opinion, what is the biggest problem facing health care and medicine today?

(a) Professional liability

(b) Costs

(c) Government regulation

If you checked (b), you are in the majority — at least according to a recent AMA poll of its members.

Cost concerns continue to be the most frequently mentioned problem, followed closely by concerns about government regulation. Professional liability came in third, continuing a downward trend that seemed to peak during 1986, and has been diminishing ever since. On the other hand, concerns about health-care access have increased slightly, as have problems associated with third-party reimbursement. AIDS was a new category added to the survey, and five percent of the respondents indicated it was the most significant problem facing medicine today. This percentage was slightly higher than the level of concern felt for problems of health-care quality.



MEDICINE MEN.

The Ohio Statehouse. The men and women in its chambers are not physicians. Yet, everyday our state's Senators and Representatives make critical decisions about legislation which can affect the quality of medical care and your rights as an independent professional.

In this election year, organized medicine's message must be heard. Our elected representatives must make informed decisions about health care issues. OMPAC, the political action committee of the Ohio State Medical Association, lets you be an active part of the force that assures your views, and those of your patients, are heard when government actions affect the practice of medicine and the delivery of quality health care. Through a contribution to OMPAC, you can support legislative candidates whose voting records and personal philosophies reflect a willingness to listen and support the views of organized medicine.

Support OMPAC.
Make an investment for yourself, your patients and your profession.



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- ☐ Better yet, both my spouse and I would like to be Sustaining Members of the Ohio Medical Political Action Committee. Enclosed is our payment of \$200.

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City / State / Zip _____

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or charge your OMPAC membership on your personal MasterCard or Visa.

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Columbus, OH 43026

OMPAC is a separate segregated fund established by the OSMA. It is connected with AMPAC, a separate segregated fund of the AMA. Voluntary political contributions to OMPAC should be written on personal checks. Contributions are not limited to the suggested amount. Neither AMA, OSMA nor county medical societies will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Voluntary political contributions are subject to the limitations of FEC regulations. This solicitation by OMPAC is not authorized by any candidate or candidate's committee. Contributions to OMPAC and AMPAC are not deductible as charitable contributions for federal income tax purposes.

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The Generic Drug Debate

By Deborah Athy

How much does it cost? These five words epitomize much about the mind-set of today's society. The resonance of the cash register is almost always just beneath the surface, whether it's in the home, supermarket, shopping mall or hospital.

Perhaps one might have thought that medicine, the curator of society's health and well-being, would be spared, that there would be no scrimping when it regarded one's health. But as one of today's most costly commodities, medicine is increasingly feeling the pressure to curtail costs.

Some individuals point out that cost-containment in medicine is essential, while others worry that a trend toward "bargain" medicine will cut into the quality of health care.

"The way it stacks up is that there is just immense political pressure for cost-containment from the government, consumer advocates and the press," says William J. Marshall, MD, a Dayton cardiologist and OSMA President-Elect. "We're continually hearing how medicine is eating up too much of the gross national product," he says.

But the problem is that many of the legislators and lobbyists don't

understand the intricacies of medicine. They're looking at the big picture, but glossing over the fine details.

"Their (the government's) emphasis is on cost-containment, pure and simple," Dr. Marshall explains. "But what is more traditional is safety and efficacy. Physicians want to save money, too, but not at the expense of our patients."

According to Dr. Marshall, dispensing generic drugs is one such area which is purported to cut costs, but may end up extracting a steeper cost in terms of patients' health.

"Government wants cheap medicine," agrees Edmond Gardner, MD, a Columbus dermatologist. That's understandable, he admits, but it may be a pipe dream. "There is no cheap medicine. Something has to be sacrificed, and that's quality."

It doesn't matter so much if you're going to the store for generic rice or beans, he continues, "But when you're dealing with your health, shouldn't you trust the traditional company?"

Generic drugs are those products called by their pharmaceutical names rather than by the registered brand name of a manufacturer.

These products must have the same active ingredient(s), dosage form, strength and route of administration as their pioneer drug counterparts.

The 1984 Drug Price Competition and Patent Term Restoration Act opened the door for the expedient manufacture of generic drugs. By 1985 generic equivalents were available for the top 10 most-prescribed drug products on the market. By 1986 approximately 1,000 drugs had received generic approval.

"Congress set the standard," says Dr. Marshall. "From that time on (1984), this thing has just rollerballed. I found I was fine as long as I could dog paddle. But now that there's a flood, I find that I can't swim."

That is, he and other physicians may be finding themselves bogged down by the sheer number of generic drugs currently available. According to a 1986 article in *American Medical News*, about 8,000 generics are currently on the market.

In the multi-billion dollar drug marketplace, business people have a lot to gain or lose in the generic drug debate, Dr. Marshall adds.

But for physicians, the big question is whether these generic products can be safely substituted

for brand name products. The Food and Drug Administration (FDA) says yes, if the generic is *bioequivalent* to the brand name product. A drug is considered bioequivalent if the rate and extent of absorption of the drug into the body is no greater or no less than 20 percent of the rate and extent of absorption of the pioneer product.

But others, including Dr. Marshall, point out that even if a drug fulfills the bioequivalence criteria, it may not be *therapeutically* equivalent.

For one thing, a generic product may contain different filler material such as binders, coating and coloring — ingredients which can make up to 90 percent of the pill. Generic opponents point out that ingredients such as sulfites, color dyes or lactose could cause serious side effects in certain individuals.

According to Dr. Marshall, what's at stake here is the well-being of the patient. "A small change in the efficacy of the drug may make a big difference in terms of what happens to the patient," he says.

In addition, other arguments against generics focus on the efficacy of the bioequivalence tests themselves. Since the 1984 law, generic companies are no longer required to submit clinical studies of safety and efficacy (as prescription companies are), but must submit bioequivalence data. The FDA contends that these guidelines eliminate the unnecessary duplicate testing of a drug product.

The standard bioequivalence testing for generics is conducted in a small number (12 to 24 subjects) of normal, healthy males. Single doses of the drug are distributed, and blood samples of the subjects are then analyzed for bioequivalence results.

Brand name manufacturers, among others, find the current bioequivalence testing suspect.

Many believe that generic companies should also be required to submit safety and efficacy studies. They also suggest that the current bioequivalence testing does not reflect a "real world" case mix. They question whether the testing should include normal subjects or patients; males or females or some mix of the two; young or old; single doses of the drug vs. multiple doses?

A recent report compiled by the Pharmaceutical Manufacturers Association (PMA) sums up: "The primary concern . . . centers on our belief that in vivo bioequivalence studies do not currently provide acceptable assurances that the two formulations deemed bioequivalent will be equally safe and effective when used interchangeably by patients."

But generic drug proponents believe that the objections the PMA and brand name drug companies have with generics have less to do with safety than with profits. That is, the more generics are dispensed, the more money the brand name companies lose.

And the FDA maintains that there have been no substantiated reports of bioequivalence in any generic drugs which have been approved and evaluated as bioequivalent.

But Tony Novello, co-chairman of the Ohio PMA Task Force, says, "I'd have to disagree. That's

not the real world." But, he adds, in some cases, problems are just not reported.

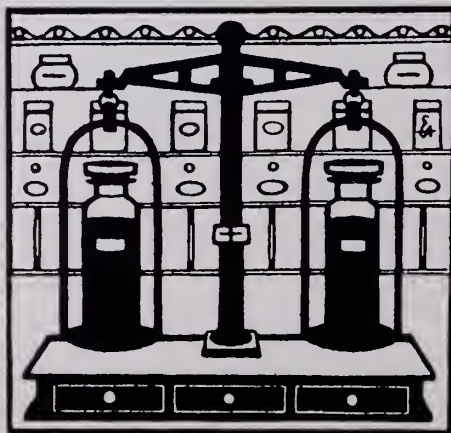
The FDA has just been going along with this issue rather than assuring us (physicians) of the safety and efficacy of the drugs, Dr. Marshall suggests. Instead of looking into these reports of bioinequivalence, they've developed a kind of double standard. Which means that while it may take two or more years for a pioneer drug to be approved, a generic drug may be approved in as quickly as six months.

"There have been myriads of reports of bioinequivalence," he continues. "There have been significant problems in many different specialties, from family practice and internal medicine to cardiology and psychiatry."

Dr. Marshall first became concerned with the effectiveness of generics when one of his hospitalized cardiology patients was given a generic substitute without his knowledge. "The next thing I knew the patient was almost in cardiac arrest," he says. "One of the key concerns is that substitution may occur without the physician's knowledge. Some of the hospitals have taken it upon themselves to substitute. It's a ludicrous situation," he says.

Dr. Gardner also became involved in the generic debates when his patients were affected. Who else but the physician is there when the patient calls and complains about an allergic reaction, or when the medication is taking twice as long as normal to treat the condition, or when a time-released medication releases no active medication in the first 10 hours?, he asks.

He agrees that there have been enough documented reports of therapeutic inequivalence in generics to cause concern. In fact, he keeps a notebook full of such published reports: "Increased Frequency with Generic Primidone" (*JAMA*, Sept. 4,



1987), and comparing generic and brand name topical glucocorticoids (*Arch Dermatol*, Oct. 1987), among others.

In his specialty there was a report of a generic hydrocortisone lotion that made the patient's skin rash worse because it contained an irritating ingredient — a preservative that the brand name didn't contain, he points out.

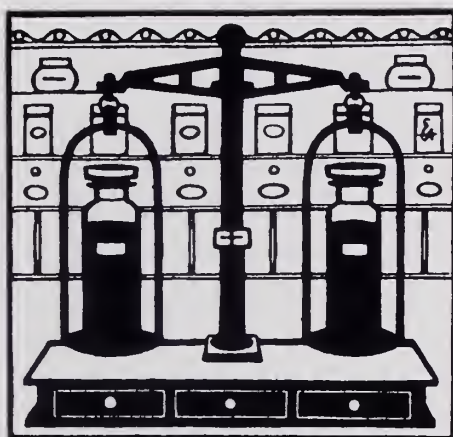
An Ohio case that gave rise to significant media coverage involved the generic anti-convulsant medication primidone. The case involved a 16-year-old epileptic patient who began to have repeated seizures after being switched to a generic anti-convulsant without the knowledge of the attending physician. Doctors at the Cleveland Clinic, where the incident occurred, reported that the drug was so ineffective that they ordered their pharmacy not to dispense any more generic anti-convulsants.

The incident was reported to the FDA, which acknowledged that in some cases certain generics "may not be equally suited for a particular patient."

Critics point out that because generics can vary by 20 percent either way from the pioneer drug, there can actually be a 40 percent variance in the drug's effectiveness.

This means that the following scenario could happen, says Dr. Gardner: A patient is given Generic A, which is found to be adequate to control seizures. When the prescription runs out, the patient is given Generic B, which is on the low end of the 20 percent mark, and the patient has a seizure. Believing that the dosage isn't high enough, the physician increases the dosage, which works fine with Generic B. But when the patient runs out of this prescription and receives Generic C, which is on the high end of the 20 percent mark, the patient may be taking toxic amounts of the drug.

Some generics have a better



reputation than others, Dr. Gardner admits. "The problem is, you don't know which generic the patient is going to get." If a well-known company provides data on a generic, the physician can be reasonably sure that it's a comparable drug. But in other cases, the physician can be left playing a guessing game: Is this the drug I prescribed? Does it contain any potentially harmful ingredients? What end of the effectiveness spectrum does it fall in? Is it produced by a respected generic or brand name company? Would I be able to identify the drug by description?

Similar reports of bioinequivalence have surfaced in various parts of the country, at Boston Hospital, where a whole series of problems was caused after an anti-coagulation drug was substituted, and in a VA hospital, where schizophrenic patients began to have complications when their medication was substituted.

According to Dr. Marshall, the bottom line is drawn this way: "Certain classes of drugs are not therapeutically equivalent. The most important areas and the ones that have probably caused the most trouble are the psychotropics, anti-convulsants and cardiology" medications, he emphasizes.

The biggest, best, and most obvious advantage of generics is that they are theoretically cheaper than their brand name

counterparts. Most reports indicate that consumers do enjoy some level of savings with generics, although skeptics point out that in many cases the bulk of the savings is not passed on to the consumer.

Dr. Marshall says that when something goes amiss with generics, complications can end up costing thousands of dollars in hospital bills and new medication, rather than saving money.

But because many doctors have had few or no problems with generics, they are content to give their patients potential cost-savings by prescribing them. And it may be true that generics with a wide therapeutic window, such as antibiotics, may work effectively and be more cost-effective than the brand name product.

As Novello points out, "We (the PMA) have never been against generics per se, but we believe that not every product is created equal. The main point is that in many cases a patient who is started off on a product that is manufactured by a particular company, whether it's brand name or generic, should be maintained on that same manufacturer's product each time the prescription is refilled. This is particularly true with certain kinds of drugs," he says.

And others agree that the debate is not simply one of generic vs. brand name, but of substitution, including generic to generic, brand name to brand name and brand name to generic.

Both Dr. Gardner and Dr. Marshall acknowledge that for many physicians, the generic drug issue is not really a priority. But they suggest that it's important for physicians to be aware of *potential* problems with generics, especially in certain population groups such as children and the elderly.

Dr. Marshall is concerned that some physicians are having a difficult time getting a handle on the growing generic market. "Physicians have enough to worry about without having to worry if

their patients are getting the drugs they've prescribed."

Dr. Marshall notes that the FDA Orange Book, which is supposed to contain a listing of generic bioequivalents, is expensive to acquire and cumbersome to read — that is if you can get a hold of one, a feat that is said to be difficult as well.

These generic lists should be available at a nominal fee and should be updated, so that physicians have a reference source for choosing or not choosing a particular drug, he suggests. Otherwise, the physician is too often left in the dark about the medication the patient is taking, unless the patient reports a change in appearance or effectiveness of the drug or there is a therapeutic failure.

According to many sources, physicians may have more at stake in the generic drug wars than they realize. Legal representatives point out that there is tremendous liability for physicians in prescribing medication that causes bad results. One expert referred to the potential liability for physicians as a "sleeping giant." Apparently, the Orange Book contains a specific disclaimer which suggests that physicians may be liable for the choice of drugs they prescribe, even if it is substituted for another.

"I don't think that every physician in the state of Ohio understands the way that medical prescriptions should be handled to ensure that the patient is getting the product prescribed," Novello points out, such as handwriting D.A.W. — "Dispense As Written" — and "Do Not Substitute" on their prescriptions.

He recommends that the PMA and the OSMA work together to disseminate information on this issue to physicians and others. "It has to be a combination effort," he acknowledges. "We should continually be providing information to the physician."

According to Dr. Marshall, the

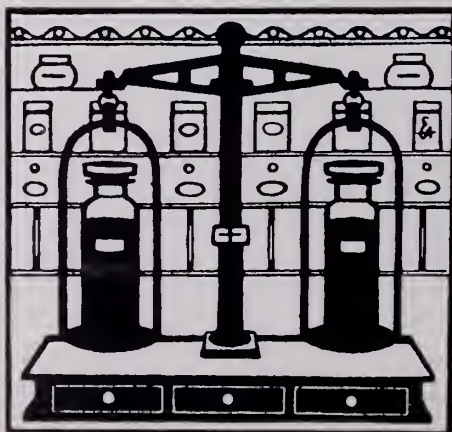
generic drug issue is a "patient advocacy issue, which physicians cannot afford not to take up the challenge. I'm doing all I can by writing articles and letters to the editor, and talking to business people, colleagues and patients," he says.

Patients also need to become more aware of this issue, and to realize that it is not just a question of dollars and cents. They should know what medication they're taking, if there's a change in the appearance or effectiveness of the drug, and should report any changes or problems to their physicians.

"In my year as president, I really want to emphasize this issue and disseminate information. One of the best places for this is the examining room. It might take a few minutes to explain the issue, but my patients really appreciate it."

What is essential, Novello says, is that the physician continues to be the manager of the prescription he or she writes. Unfortunately, that's not always the way it turns out, even when physicians take the extra steps to write D.A.W., for example.

"Ultimately, it should be the physician's decision," Dr. Marshall agrees. "If the physician wants to substitute generic tylenol, that's fine," but it shouldn't be substituted without the physician's approval.



When all is said and done, "We don't care where the drugs come from," he continues, and we don't want to get involved in the business aspects. "We just want the best products for our patients."

But for now, Dr. Marshall admits, some physicians don't think there's a problem with generics. Others don't consider it a priority. In short, the opposition to generic drugs is too dispersed, he says.

In order to remedy the situation, there needs to be increased pressure and heightened awareness among legislators, constituents, pharmacists, physicians in practice and in academia, and patients. "We need a consensus in order to have a bigger 'swat.' I don't think we'll get there if we do it individually," he says.

But by making a concerted effort, physicians *can* make a difference. At the 1988 OSMA Annual Meeting, Janet Bixel, MD, OSMA representative for the Ohio Medicaid Drug Formulary, pointed out that the HCFA temporarily removed a number of brand name drugs from the drug formulary, including cardiac, psychotropic and anti-convulsant medication until the physicians banded in opposition.

"The physician community responded with letters and we were able to return these drugs to the list. Despite Medicaid's financial troubles, we'll try to keep anti-convulsants on the list," she vowed.

But she added, "We are in a cost-crunch. We need to keep Medicaid patient costs down without jeopardizing cost of care."

For now and in the not-so-distant future, the generic debates are far from over. Some say there's still too little information. Some say there's enough information to cause concern.

A middle-of-the-road approach might acknowledge that it's important to curb medical costs,

and that generic drugs may be appropriate in some cases, especially when the medication has a wide therapeutic window. But for other classes of drugs that have already caused problems when substituted, it may pay off in the long run to stick to the brand name product.

A recent article on the subject pointed out that because bioequivalence is a relatively new science, current methodology can be expected to improve, which could only be good news for patients and physicians alike.

In the meantime, "We question the testing procedures that are in place and worry about some of the products out there," Novello sums up.

Perhaps the first step is to increase awareness and education about the issue throughout society, and to promote an overall philosophy that encompasses a balance between acceptable cost and quality care.

"If someone would have asked me 20 years ago," Dr. Marshall explains, "I would have said there was no problem (with generics). But now it's become impossible to separate the wheat from the chaff. We want that confidence and proof in prescribing that we used to have." **OSMA**

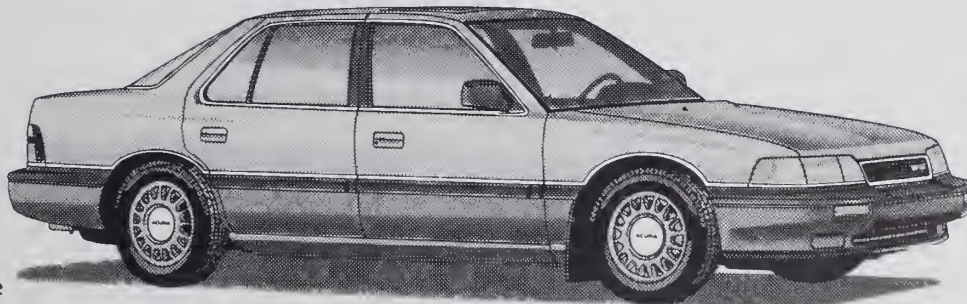
Deborah Athy is Associate Editor of OHIO Medicine.

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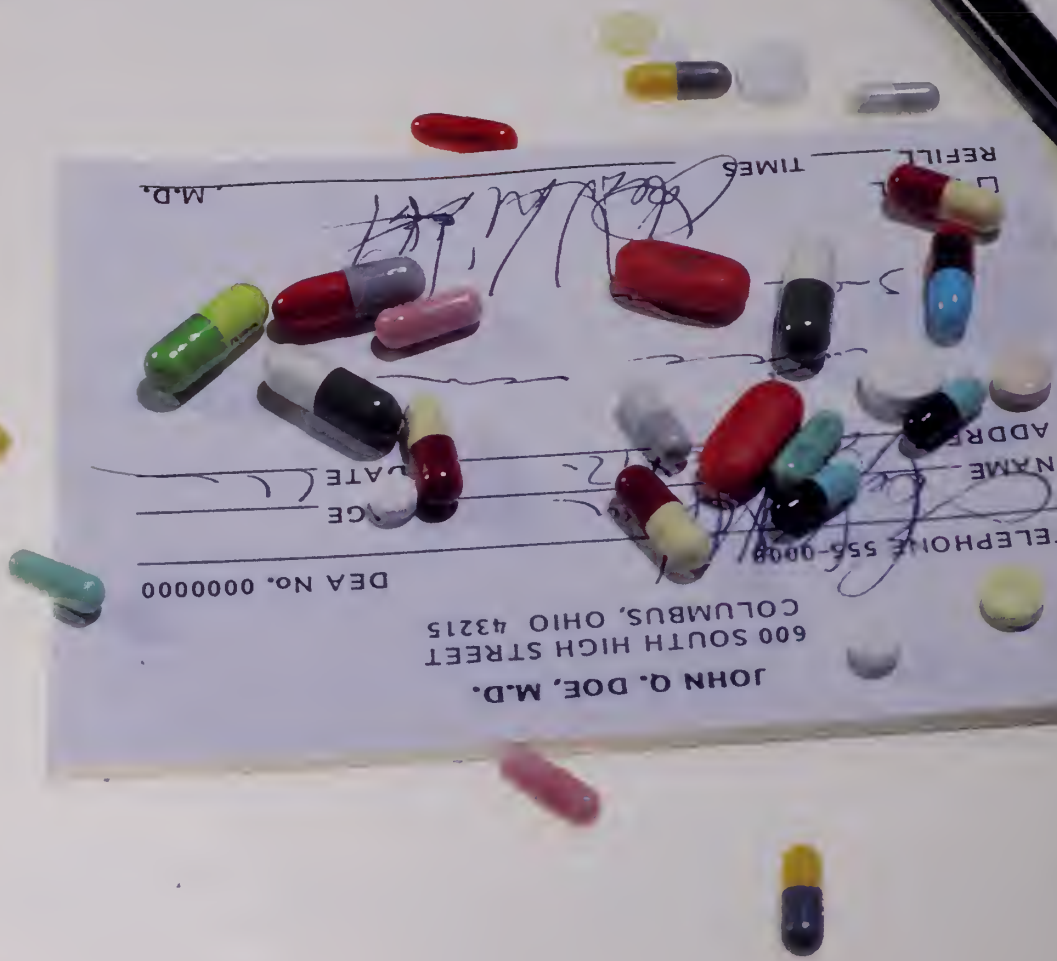
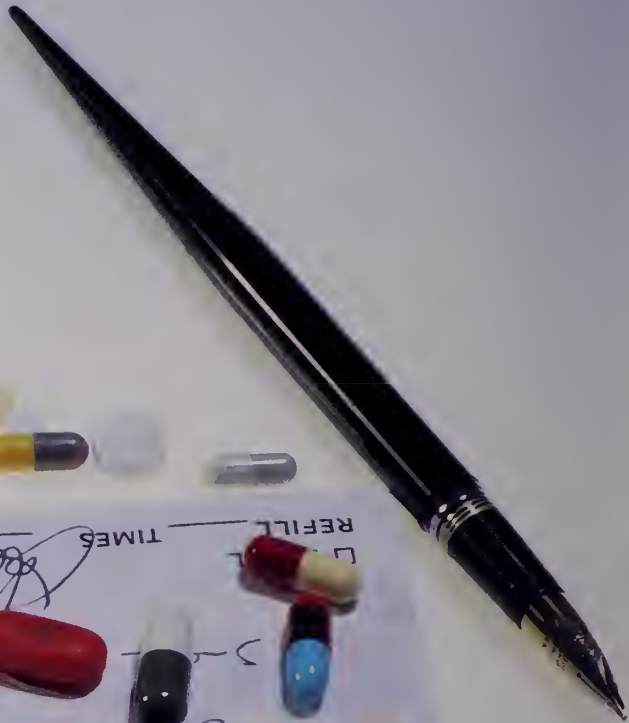
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Let the Prescriber Beware!

By Karen S. Edwards

Now that you've read the pros and cons of prescribing generic drugs, you may think you're ready to make some decisions with regard to your own prescribing habits.

But before you hand that prescription over to your patients . . . wait! There may be a few more things you'll want to consider first.

For example:

1.) On what are you basing your decision to prescribe or not to prescribe generic drugs?

The biggest, and possibly the only advantage of generic drugs is that they usually cost considerably less than their brand name counterparts, which means they will save your patients some out-of-pocket expenses, while assuring government and third-party payors that you're working with them to hold down costs.

To be perfectly fair, however, it must also be mentioned that generics *do* reduce the cost of a pharmacy's inventory, both in the number of drugs kept on hand and in their cost. Consider, if you will, a brand name drug that a pharmacist can obtain for a cost of about \$15. Because of the current intense competition among pharmacies (thanks, largely, to the large drugstore chains), the

pharmacist can — maybe — sell that drug for \$19.95. In other words, the pharmacy can realize a \$4.95 return on his \$15 investment. Now, consider the generic equivalent of that brand name drug. The pharmacy might be able to purchase the generic for \$5 and turn around and sell it for \$19.95. That allows the pharmacy to save your patient more than half of the typical prescription cost of that drug, and also pick up a better return on the pharmacy's investment in stock.

It would be wise to keep in mind, then, that there is definitely an incentive for the pharmacy to dispense a generic to your patient — especially if that pharmacist is an independent practitioner.

"I don't feel any need for the pharmacy to make a profit for the hospital," qualifies Tim Moore, RPh, Senior Director of Pharmacy at Ohio State University Hospital in Columbus. He concedes, however, that there *is* pressure from the hospital to hold down costs "and generic drugs are one tool that I have that will enable me to do so."

You and your patient still have the right to refuse a generic product, of course, but you can be assured that, unless you clearly write "D.A.W." on the prescription

■ *Before you hand that prescription to your patient . . . wait! There may be a few more things you'll want to consider first.*

■ *Writing D.A.W. on every prescription is not a very scientific way to prescribe, says Dr. Bixel. The best approach is to take each case individually.*

blank, the question "Shall I fill this with a generic drug that will cost less than what is being prescribed?" will come up at the pharmacy.

An aversion to bioequivalents may be enough to have you scrawling D.A.W. on all future prescriptions — but restricting your patients to brand name-only drugs may not always be the wisest course to take.

Robert Reid, RPh, a private practice pharmacist in Columbus, and chairman of the Ohio Medicaid Drug Formulary committee explains:

"I can empathize with the physician who wants to work with a 'given.' If I were a doctor who worked with cardiovascular patients, for example, I might have a tendency to write D.A.W. on all prescriptions myself, so that I would have a consistent basis to evaluate my patient's progress." However, by doing so, you may alienate patients. Moreover, Medicaid patients may not be able to get the brand name drug unless you provide documented evidence that the generic drug is dangerous to that patient's health.

"Writing D.A.W. on every prescription is not a very scientific way to approach prescribing," agrees Janet Bixel, MD, a Columbus endocrinologist who serves as OSMA's representative on Ohio's Medicaid Drug Formulary committee.

The best approach, she says, is to take each case individually, and examine both the brand name and its generic equivalent side by side. Then make your decision, based on your findings from this study.

Reid and Dr. Bixel agree, however, that information on generic products is not all that readily available — at least not to the practicing physician.

"The generic industry does not have detail people," Reid explains.

"They have salespeople, and not many of those are travelers."

And not many of the generic company's sales staff calls on physicians, either. Most of them, in fact, restrict their contacts to pharmacists.

"If you have a question about the safety or effectiveness of a bioequivalent, you should be able to turn to your local pharmacist for the answers," says Frank Wickham, director of the Ohio Board of Pharmacy.

"And if the pharmacist can't answer your question, then contact us," continues Wickham. The Ohio Board of Pharmacy keeps active, up-to-date files on the generic drug marketplace, "and of course, we can always reach the FDA if there is anything we can't answer," Wickham continues.

Of course, physicians can also contact the generic drug companies, if they wish.

"Most of these companies have public relations staffs which will take your call and probably hook you up with the physician on staff," says Reid.

The FDA Orange Book can also provide some guidance, says Wickham — if, of course, you're willing to invest the \$107 for its annual cost. It's interesting to note, incidentally, that most pharmacies do not make that investment, preferring to stock their shelves based either on recommendations made by their colleagues through the professional journals, says Reid, or on their faith in the credibility of the generic companies they are buying from.

If you *do* happen to secure information from the various generic companies, though, Wickham urges you to study it very carefully.

"We have some examples in our office that show just how false and misleading some of these claims

can be. Unless you've been trained how to evaluate scientific literature, you could be seriously misled."

Tim Moore relates how his hospital pharmacy selects its inventory, and if you're presently in the process of trying to decide which generics might be acceptable for your patients, you might want to follow his lead.

"First of all, we consider the FDA Orange Book the standard on generic selection. Despite the plus-or-minus 20 percent variation allowed by the FDA, we've not heard much concern about the drug selection from our staff," he says.

The pharmacy selection committee also sets aside time to evaluate the generic literature that has been supplied by the generic drug manufacturers.

"Although the Orange Book is a guideline, pharmacists are not bound to use only those drugs described in the book," says Wickham. "If they have enough data available to make an informed decision, they can dispense a generic that is not presently in the book — and may never be in the book."

Because of his hospital's university setting, Moore says, experts are generally available to examine and evaluate the bioequivalent data.

"The product undergoes our own in-house review, and we make an internal decision as to whether or not it goes into our pharmacy," he comments.

Finally, Moore says that his committee, like most physicians, is comfortable with those generic products being manufactured by the innovator companies, and he says they are frequently included as part of the pharmacy's inventory.

2.) You've considered all the facts and have decided that generics are all right in some instances — but

not in yours. Now what?

If you happen to be practicing in one of the specialties that deals daily with patients with life-threatening illnesses, know that most of the sources contacted for this article tend to agree with you. These patients, they say, are not prime subjects for generic substitution.

If you do *not* want a generic drug dispensed to your patient, there is only one thing you need to do. Pick up your pen and write D.A.W. on the prescription.

That does *not* mean stamping it on in big red letters — nor does it mean having your secretary type it on — nor does it mean using those handy prescription blanks which the drug company gave you, with the letters D.A.W. neatly pre-printed on the front. It *does* mean picking up your pen and putting down D.A.W. in your own handwriting. This is the *only* D.A.W. which pharmacists — by law — must observe.

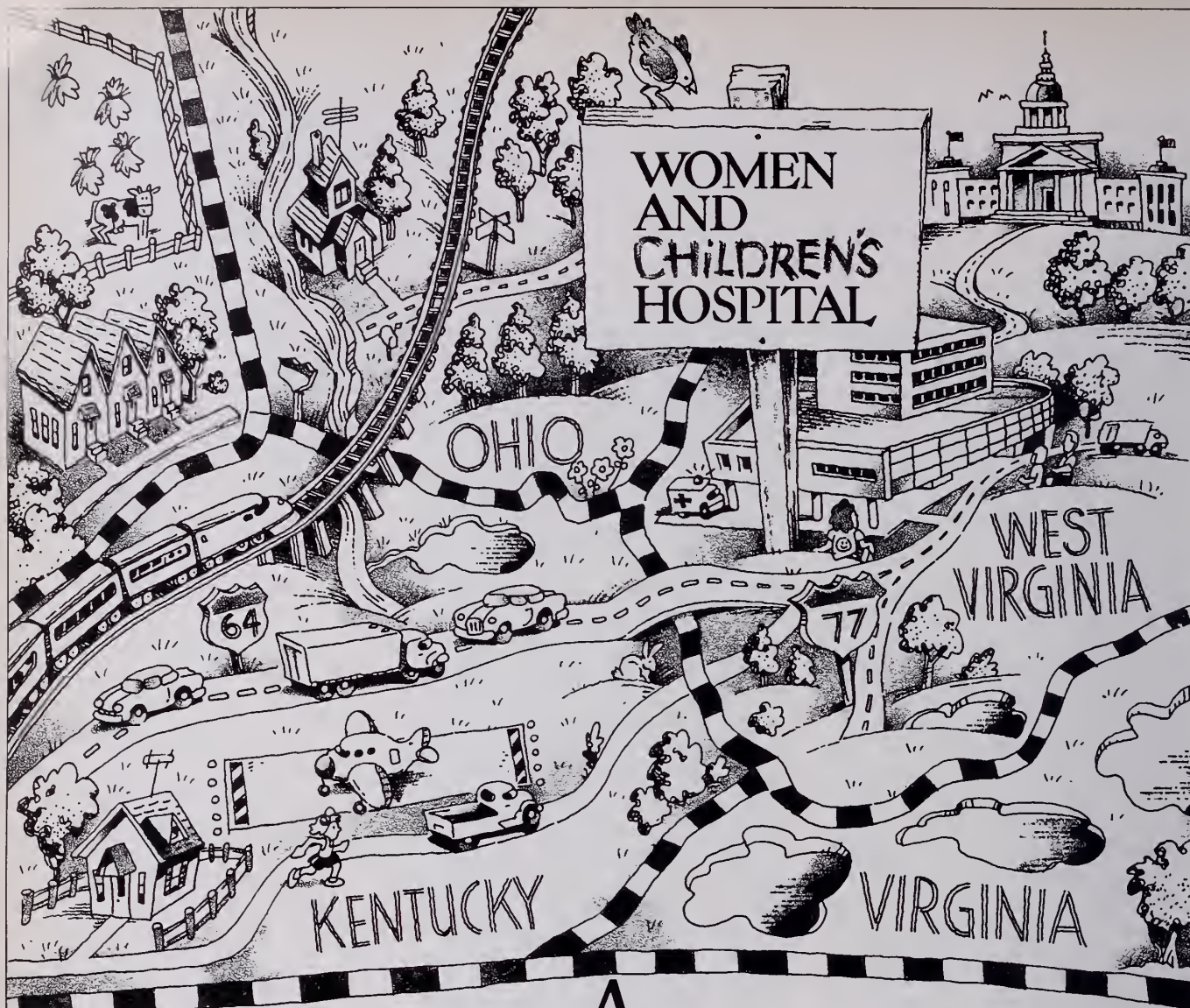
"I remember when the law was being considered by the General Assembly that the intent was to make it a very conscious act on the part of the physician," says Wickham.

The pharmacist *may* honor a D.A.W. stamp, or the typed letter or the preprinted order form. If the pharmacist knows you, he or she may call your office to have you orally confirm the order. But the point is — they don't have to, and most times will not. It's up to you, the prescriber, to make that conscious effort to write D.A.W. if you want the brand name drug dispensed.

Similarly, it's up to you, or the staff member in your office who phones in your prescriptions, to tell the pharmacist, "This drug is to be dispensed as ordered."

"I'd say that only 1 percent of the time will a nurse or the person
continued on page 737

■ *If you practice in a specialty that deals daily with life-threatening illnesses, most sources say these patients are not prime subjects for generic substitution.*



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making the call tell us to dispense the drug as ordered," says Reid.

And chances are, the pharmacist is not going to ask your staff whether or not the drug is to be dispensed as prescribed — so it's up to you to alert your staff to add the "dispense as ordered" message (if that's indeed what you want) to all future calls to the pharmacy.

"Just because a physician has written down Lasix on his form does not mean that the patient is going to get Lasix," says Reid. "I believe there are a lot of doctors out there who assume their prescriptions are being filled as written, yet I'd estimate only 9 percent of today's prescriptions are being written with D.A.W. indicated on the prescription."

Dr. Bixel, however, believes that many doctors are comfortable with generic drugs, and omit the D.A.W. on many of their prescriptions.

"I think there are a lot of generic drugs out there with which doctors are very comfortable with, and they feel free to either prescribe them, or to allow the pharmacist to substitute them for the brand name," she says.

However, simply assuming your patient is receiving the brand name product without your handwritten D.A.W. is presumptuous — and even dangerous in today's marketplace. Don't do it, urge the experts.

3.) You've decided that generics are perfectly acceptable for your patients. However, before you prescribe . . .

First of all, understand that toxicity levels may differ in generic products, and for that matter, from one generic to another.

"In many generic products, the drug is more 'available' to the patient because it is absorbed faster or more completely than the brand name product," explains

Wickham.

This means, then, that a very fine line is often drawn between the drug's therapeutic value and its potential toxicity.

"It can be especially dangerous for children or the elderly," says Wickham, who urges physicians to use caution when prescribing or authorizing generic substitution for patients in these age groups. "If there is a narrow therapeutic window, the effects of the drug may go from therapeutic to toxic as the difference in strength pushes the patient over the border."

Another factor you'll want to consider before approving a generic equivalent is "what are this product's inactive ingredients?" The FDA does not explore the issue of inactive ingredients in its assessment of bioequivalents, yet it seems to be an area that is creating problems.

For example, Board of Pharmacy Director Wickham cites the case of a patient who was receiving an analgesic intravenously. Complications set in — not because of the generic itself, but because of a preservative the generic contained.

Other problems might arise if your patient is lactose or glucose intolerant. Check the product's list *before* you prescribe to make sure its ingredients are not going to create a problem for *your* patient.

By and large, however, it's not a generic's inactive ingredients — or even its potential toxicity — that is bringing in the greatest number of complaints, says Wickham.

Instead, therapeutic failure seems to be currently causing the most concern — both among physicians and patients.

"We're receiving more reports on drug failure than ever before," Wickham notes — adding that even some brand name drugs are being reported.

Physicians need to be aware

■ *"If there is a narrow therapeutic window, the effects of the drug may go from therapeutic to toxic as the difference in strength pushes the patient over the border."*

that this is a factor, and careful monitoring of the patient's progress on a generic product is a necessary precaution.

Of course, adds Wickham, therapeutic failure may occur — not because of the drug itself — but because of some outside influence.

"We had one patient — a diabetic — come into our office and tell us that drug he was on was not working, that his blood sugar level was elevated, and so on. It turned out that the product was not really to blame. The patient was suffering from the flu, and the flu's effects somehow affected the efficacy of the medication. No one, however, had taken a look at this possibility," he finishes.

The prescriber needs to examine such factors before drawing conclusions about the product, adds Wickham — and that holds true for either the brand name or generic versions.

4.) In either case . . .

There are definitely some things you're going to want to do — whether you've decided to authorize/prescribe generics for your patients or not.

For example, you may want to make it a practice to check the medication that was dispensed to the patient on his or her next visit to the office. Were the pills dispensed as written? Are the pills the specific generic product you prescribed or was another generic product substituted? If you did not prescribe a specific generic, is the name of the product dispensed — and its manufacturer — printed on the label so that you can check through the bioequivalency data on this product if you wish? (By law, it should be there.)

Some physicians have even trained their patients to check the medication before leaving the pharmacy to make sure that they

received what was prescribed.

Unfortunately, such demonstrations are sometimes necessary.

A physician who appeared recently on a televised program on generic prescribing noted that 3 percent of his patients said the pharmacist tried to dispense a generic, despite the D.A.W. on the prescription.

And his is no isolated incident. Other, similar reports have appeared in professional journals — including *JAMA* — and on a more local level, from OSMA President-Elect William J. Marshall, MD.

Dr. Marshall wrote in the October 1987 issue of *Dayton Medicine* of three cases of unauthorized generic substitution that occurred in his practice. Two involved independent pharmacies, one a hospital pharmacy. In all three cases, the substitution was due more to a lack of care than to any deliberate gesture on the part of the pharmacist. In two instances, Dr. Marshall reports, the original prescription had not been reviewed when the patient went in for a refill. In the other instance, the pharmacist had not paid adequate attention to the prescription and had simply overlooked D.A.W.

"Any complaints we receive of pharmacists not complying with the D.A.W. handwritten on prescriptions are investigated," says Wickham. "If it's found that a pharmacist did not comply, he/she will be warned."

After all, Dr. Bixel points out, "Pharmacists who are substituting generics when a D.A.W. has been written on the prescription are breaking the law."

She believes, however, that such instances are rare.

"Still, doctors need to be more careful about their prescribing

■ *The prescriber needs to examine a variety of factors before drawing conclusions about the product — whether brand name or generic, says Wickham.*

continued on page 740



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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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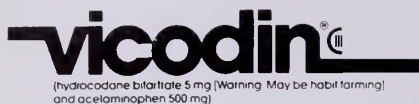
1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reaction: VICODIN contains sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than non-asthmatic people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. (see ADVERSE REACTIONS: Respiratory Depression).

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: As with any narcotic analgesic agent, VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind. **Information for Patients:** VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Use in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1.0 mg/kg q6h, and paregoric 2 to 4 drops/kg q4h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.

Labor and Delivery: As with all narcotics, administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur, they are more frequent in ambulatory than in recumbent patients. The antiemetic phenothiazines are useful in suppressing these effects; however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Urteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS.)

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use and the incidence of untoward effects is dose related.

The usual adult dosage is one or two tablets every four to six hours as needed for pain. The total 24 hour dose should not exceed 8 tablets.

Revised June, 1987

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Let the Prescriber Beware . . . continued

habits. They need to remember to handwrite the D.A.W. on a prescription if they feel strongly about their patients receiving brand name drugs," she stresses.

Tim Moore points out that patients have the habit of switching pharmacies fairly frequently. The pharmacist who knows you and your patient — and knows you always want your prescription dispensed as written — is more the exception than the rule these days, so take extra care in writing all of your prescriptions, the experts urge.

Also, alert your patients to notify you of any side effects, adverse reactions or drug failure they experience. As has already been mentioned, you'll want to do your own monitoring of your patient's progress on the prescription — but it doesn't hurt to have the patient aware of some of the problems that can arise — and to keep his/her own eyes open for them as well.

5.) What is your liability concerning generic prescribing?

Let's say you've decided that a generic product is safe and bioequivalent to the brand name drug you typically prescribe. The patient you're currently treating is a young woman — a single parent who needs a break on her prescription costs. You authorize the pharmacist to dispense a generic and, unfortunately, you learn on her next visit that she had had an adverse reaction to the medication. Are you liable?

According to Ohio law, you are not — IF you had no "reasonable cause to believe that the health condition of the patient for whom the drug was intended warranted the prescription of a specific brand name drug and no other." (ORC 4729.38)

Nor is the pharmacist "who selects a generically equivalent drug" liable for dispensing that

generic — unless, of course, he or she ignored a D.A.W. order — and even then there is no guarantee that the case against the pharmacist will stand up in court.

"We have had only one case in the U.S. where a non-approved generic drug was dispensed by a pharmacist and the patient died as a result," says Wickham.

The pharmacist was charged with involuntary manslaughter.

"He was acquitted, though," says Wickham. "The defense attorney brought in doctors to testify that in their opinion, the drug was considered safe, and it cast enough of a doubt in the jurors' minds that they were unable to convict him."

The case, however, went on to the civil courts.

"It may have been decided by now," admits Wickham. "Once a case goes to the civil courts, it's usually settled out of court, and we lose track of it."

Wickham acknowledges that the laws were specifically worded on this matter to give both the physician — and the pharmacist — a break.

"Because of the move to HMOs, the decision on what drug to prescribe or dispense is not always that of the physician or pharmacist, but instead, that of a management team," he says.

And, as more and more third-party payors insist on the use of generic substitutes for their insureds, the situation of what is being prescribed may only get worse.

Dr. Bixel, however, thinks that while more and more generics are bound to be dispensed in the future, it won't be because the third parties are insisting on it.

"The third-party payors are trying to mac (set a maximum allowable cost) everything these days, and they encourage generic prescribing, but many of them are

pulling back from insisting on it. Maybe the companies have decided that it is not in their best interests to dictate to doctors how to prescribe — or to encourage pharmacists to break the law by refusing to follow a D.A.W. order written on a prescription,” she says.

Nor is the government forcing the issue of generic substitution for all drugs, she adds.

“There is a lot of confusion out there about the Medicaid Drug Formulary,” says Dr. Bixel. “Many doctors believe that all brand name drugs have been removed from the formulary, and this is simply not true. The formulary has a number of brand name drugs. In fact, if there is no good evidence to show the generic is bioequivalent to the brand name drug, the brand name is always left in the formulary.”

... Or returned, as was the case recently with some anti-convulsant drugs which were added back into the formulary after the case to reinstate the trade name drug was effectively pleaded.

“We feel that as long as the generics are bioequivalent, they’re fine. They allow the patient and Medicaid to save money. If they’re not bioequivalent, we’ll fight to make sure the brand name stays in,” says Dr. Bixel.

It all comes back, then, to the physician’s ever-present role of patient advocate — of remaining vigilant to make sure patients receive quality health care.

“Generic prescribing will always be something of a testing ground,” comments Robert Reid — and it is the physician who must ultimately make the decision on just how far those tests will go.

Should you prescribe generics? Should you write D.A.W.?

The choice is yours, but make it an informed choice, say the experts — one that accurately reflects the merits of today’s pharmaceutical

marketplace. And remember, while state prescribing laws may have relaxed slightly the liability of the physician prescribing bioequivalents, it is still your responsibility to learn as much as you can about the drug — generic or brand name — that you prescribe. **OSMA**

Karen S. Edwards is Executive Editor of OHIO Medicine.

■ *It all comes back, then, to the physician’s ever-present role of patient advocate — of remaining vigilant to make sure patients receive quality health care.*

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By Michelle J. Carlson

Generics or Brand Names?

What Ohio Physicians Are Prescribing

O*HIO Medicine* contacted 10 physicians from various specialties around the state and posed the following question: Do you prescribe brand name drugs or generic equivalents for your patients? Their answers and explanations follow.

I usually prescribe the brand name, not because I don't believe in the generic, but because in case of a bad reaction, (the patient) could say you didn't order the brand name. I don't think you have as many problems in OB/Gyn (as you might in other specialties) except maybe in OB because you're dealing with a pregnancy . . . All the drugs you order, you do with care. I just haven't gone with the generics because I have a prime practice and I want to give my patients prime care."

— **Raymond Lupse, MD**
Obstetrician/Gynecologist
Youngstown



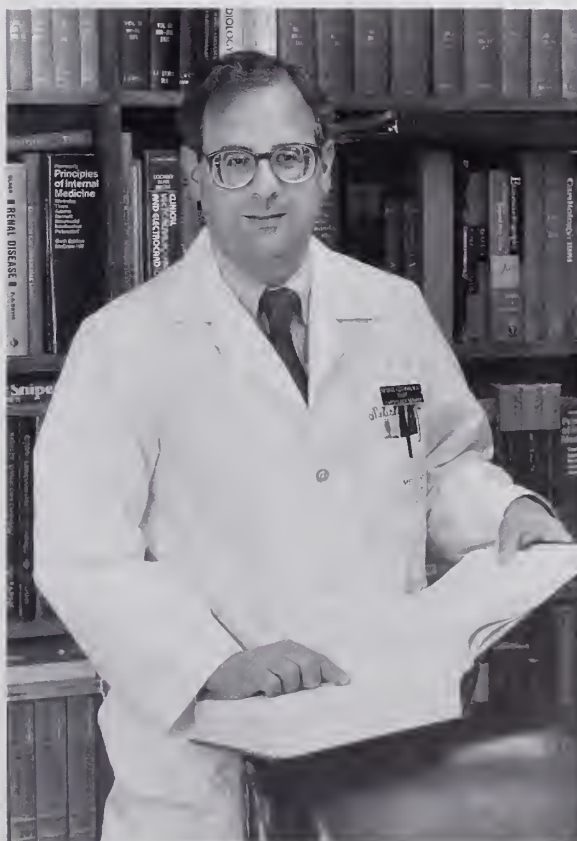


I'm a surgeon, so I have a relatively limited number of drugs I prescribe, but I always use the generics, mostly because they're cheaper than the brand names. At least that's what I understand . . . I mostly prescribe pain killers and antibiotics for patients after surgery, and I haven't had any problems with (generics)."

— **John Raaf, MD**
General Surgeon
Cleveland

I prescribe the brand name, and let me tell you why. Last week, I had a woman I'd been following with serious heart failure . . . and she ended up in the hospital. I wanted to know why she'd been coming along so beautifully and suddenly went downhill. It turned out she was on a generic. I don't know what they're using in them, but this woman got immediately better when we switched back to the brand name. These drugs just don't appear to be bioequivalent even though (the companies) say they are. . . . Clinically they're ineffective. I don't care what their tests say."

— **George Litman, MD**
Cardiologist
Akron





I usually prescribe generic equivalents. First, because I don't think one chemical is different from another. I don't think it makes a big difference if I order a drug from (one company or another). Second, most pharmacists tell me they will give the patient the lowest-cost item, and I tend to take them at their word. I haven't had any problems (when prescribing generic equivalents)."

— **Frank Foss, MD**
General Surgeon
Toledo

I prescribe both, but it depends. There are certain generic 'equivalents' that aren't equivalent, and when I discover that, I prescribe the brand name. I had one patient who was not doing very well, and it turned out she was on the generic. We switched back to the brand name and she was fine . . . (Generics) don't all work. There's a lack of quality control. I think the FDA is too lax in regulating them."

— **Jerome Logan, MD**
Psychiatrist
Dayton

I do both, but I rarely prescribe brand names . . . because a lot of my patients can't afford brand names or they have insurance that will only cover the cost of generics. I'll write the brand name, but I won't put D.A.W. That way (the patient) can decide."

— **Diane Helentjaris, MD**
Family Practitioner
Dayton

Basically there are certain drugs that I'm more familiar with by their generic name and some that I'm more familiar with by their brand name. I usually (prescribe) the one I know. When I'm writing a prescription, I indicate that (the patient) can make the decision (whether to get the brand name or the generic.)"

— **William Bernie, MD**
General Surgeon
Dayton

I prescribe both. When I know it's apparent that the brand name is better absorbed and has a better effect, I prescribe the brand name. When I don't know, particularly if it's not life-threatening, I use generics because of the price difference. I haven't had any bad reactions, but some patients think the generics aren't as good as the brand names."

— **Thomas Saladin, MD**
Gastroenterologist
Cincinnati



"It's quite variable. Usually I prescribe the brand name because to some extent, if we're too harsh on the drug companies — the ones that spend most of the money on drug research — we're going to find that they'll start investing in other things, so I feel the need to recognize and support them. I also have more confidence in them than I-don't-know-what-company making the generics. I don't know where these things come from."

— **Ralph Lach, MD**
Cardiologist
Columbus

"If the patient wants the brand name, then that's what I'll prescribe. If he wants the generic, then I'll prescribe that. It has to do somewhat with bioequivalence. The generics only have to have 75 percent of the active control, (so) I'll try and talk them out of the generic if they aren't very active. Also, some generics use clay as binders, and some of my patients complain that it goes right through them. Brand names, though, use binders like lactose — milk sugar — which is more easily absorbed."

— **George Clouse, MD**
Family Practitioner
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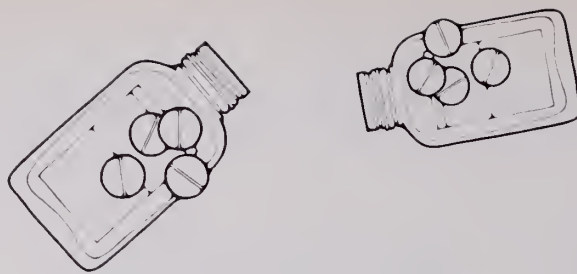
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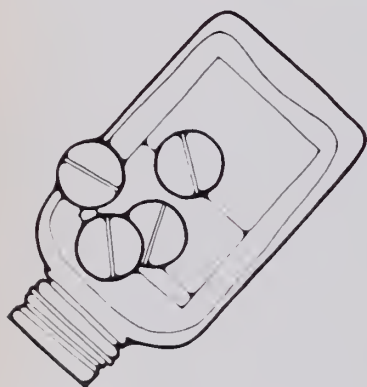
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Why People Don't Take Their Medicine

By G. Dixon Clouse, MD



Better patient compliance is important in achieving adequate and continuing control of illness; in fact it is crucial.

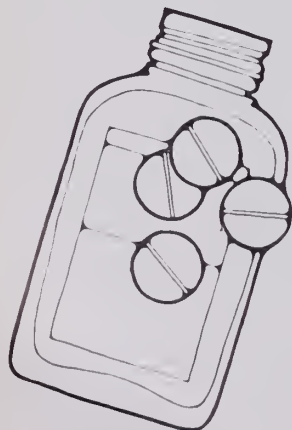
It has been estimated that as much as 75 percent of prescriptions never get filled, and as much as 75 percent of the prescriptions that are filled are never taken, at least in the recommended amount.

Why don't people take their medicine? The reasons are many. Drawing on over 40 years in general practice, some unusual situations have appeared. Sometimes it begins with the physician. If the doctor says, "Why don't you try this medication?", then the patient gives it only a half-hearted try. Instead, the physician may say something like this: "A number of my patients have had very good results from this medication. Do you want to see if it will help you?"

Or the doctor may prescribe too much of a new medication and when patients find out at the pharmacy how much it will cost, they decide not to get the prescription filled.

The doctor may say, "Here are some free samples to try." People instinctively distrust free samples which they think are not worth very much or they wouldn't be free. Instead the physician may say, "Here are some starter tablets (or capsules) to take until you get this prescription filled."

So the physician's attitude is very important. Not only must physicians sell themselves, convincing the patient that they have made the right diagnosis, they must also know what they're doing, and thoroughly understand what is wrong and the best medication to use, but physicians must also sell the medication. Physicians must convince the patient of the importance of taking the medication, what to expect in benefits, what could be the most common side effects, whether to take the medication before or after meals, possible interactions with the patient's other medications (especially people on multiple medications), the possible adverse effects (such as photosensitivity with tetracyclines), adjustments to people's schedules of work or school, adjustments to lower doses



for younger or thinner patients, and adjustments to lower doses for elderly patients.

The physician should always know what the medication looks like (explaining that if they get generics, they might look entirely different) or acts like (fizzing, as in some potassium preparations, or forming a thick drink as in some of the bulk laxatives), and the best or most convenient way to take the medication.

The size makes a difference too. It is interesting that some people perceive a small pill to be more effective, and some people complain that the physician prescribed "horse pills," but distrust tiny pills. Some people claim they can't swallow a tablet or capsule, and appreciate it when the physician prescribes a liquid. The fact that they can swallow easily a piece of chicken the same size makes no difference to them.

Physicians should be relatively knowledgeable about the cost of the medication, but since pharmacies differ, no set price should be stated. Patients appreciate the doctor's concern in being cost effective.

Some patients really don't want a prescription, but prefer a shot, which they perceive as being more effective. Some people visit a doctor to find out if they have cancer or serious illness, and having been reassured, they believe an expensive medication unnecessary. Most people think that a capsule is more effective than a tablet, while some have just the opposite view.

For awhile, some people feared that capsules could be laced with poison, but that fear seems to be allayed since manufacturers put capsules in tamper-proof bottles.

Some people perceive that a green medication is preferable to a pink one, and some have just the opposite opinion. Other people prefer other colors, i.e. they think that a red capsule is more effective than a blue one.

Some patients want the "real thing," the brand name. This is especially true if their insurance covers the cost or most of it. Some people have a basic uneasiness about generic drugs, believing them to be inferior. This is sometimes true when the medication is made by a fly-by-night company which is not subject to the testing standards of bio-assay of 75 percent active ingredients, or a company that uses clay as an excipient instead of starch or lactose. The bottom line is bioavailability. Some clay excipient medications pass right through the patient, apparently unchanged in the stool. They get little results, so the patient stops taking the medication.

Other people do perfectly well on generic drugs and insist that the amount prescribed be for a four-month period so they can send away for them at a much reduced cost.

Some people have more faith in what the doctor gives them than in what the pharmacies prepare, because either through personal experience or what they have been told, pharmacies have given a substitute medication or even made errors, causing them to mistrust pharmacies. Some people have not filled prescriptions because "the pharmacy was closed" or "too far away," or their "car broke down" or the "dog ate it" or the "parrot ate it" or it was "accidentally flushed down the toilet," or it was in their purse which was stolen or lost or there was no one to go to the pharmacy for them.

Most of these reasons translate in a patient's mind to: "If I don't feel better by payday, then I'll get the medicine."

Some people may feel better mentally after seeing the doctor and forget they had a prescription to be filled, or take the prescription to the pharmacy, begin to feel better and "forget" to go back and pick it up.

Sometimes after seeing the

doctor and hearing that nothing is seriously wrong, they reason, "Why spend the money when the illness will be gone in a few days and I can get better by myself without spending more money?"

Some people are afraid of the side effects of medication once the

Some people even pride themselves about never taking any medication.

doctor has explained to them the risks, or if friends or relatives have told them they became sick or had bad effects after using the same drug. People do talk to each other about medications. Television reports, newspapers and magazines may describe dangerous side effects, and some people even have miniature PDRs or books describing the most common drugs and their adverse reactions.

With this kind of patient, physicians may counter objections to a certain drug by saying something like, "If you read all the possible side effects of a drug, you wouldn't even take an aspirin. Besides, the good effects far outweigh the bad effects."

Because of a fear of all drugs, some people are therapeutic nihilists and won't take any medication and even pride themselves on never taking any medication. Some of these people believe that their own body will heal itself, or that their faith in God or miracle healers or bathing in the pool at Lourdes will cure them. Others believe certain diets will effect a cure or that unusual herbs or "natural" elements purchased in a health food store will bring good health.

A physician should always inquire what a patient has already taken and what results were

continued on page 749



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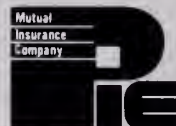
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obtained because a patient won't get a prescription filled if it's for the same medication that didn't do any good.

Then there are people who would, it seems, rather suffer and complain than be cured. They are the ones who usually complain that they have been to too many doctors who are unable to help them.

There are also people who've had a friend or relative take the same medication and died or felt worse.

The most common reason patients don't get a prescription filled is that they find the medication too expensive. That's the bottom line for most people. They rationalize that the doctor didn't emphasize the absolute need for the medication or they didn't understand what the medication was for.

So if a patient does get the prescription filled, why doesn't the patient take the medication? People who have insurance usually get them filled. They believe they are getting "something for nothing" and have the attitude that they worked for years for this "free" service.

Some Medicaid patients who get prescriptions for an expensive antibiotic plus a prescription for a product containing codeine have been known to throw away the antibiotic and take only the codeine.

Some people want results in a couple of days, and if they're not helped, they will stop taking the medication. Others may take the medication for only a few days, and, feeling better, they put it away to take only if they start to feel bad again and the condition comes back. This is especially true for medication for sore throats, and the complete regimen for 10 days seems unneeded. They save the medication for another spell of

illness.

Some people put the medication out of the reach of their children and forget where they hid it. Others lose their medication or have their purse containing the medication stolen, or the parrot "got into it and died," or it "fell in the toilet."

Some medications disintegrate into powder after being jostled around in the bottom of a handbag for days, or, after exposure to moisture or wet hands, stick together or come apart. These patients are embarrassed to tell the doctor what happened and don't want the expense of a new prescription.

Many patients carry around with them a little box containing a variety of drugs, most of which are past their expiration date as well as being unlabeled. These seem to be carried as a "security blanket" just in case they may be needed at a time when a pharmacist or physician is not available. The patients who carry around medications derive some benefit from just knowing they may use them if needed.

A little known reason for non-compliance is that many people were forced to swallow bad tasting medication as children and, as adults, they still balk at taking medication on a regular basis.

Some of these people accept medication if it is handed to them by another person dose by dose, but they are reluctant to do it for themselves.

Many patients who stop taking medication do so because of unpleasant side effects, such as headaches, nausea and diarrhea, impotence, vaginal itch or feeling "funny in the head" or their Aunt Minnie wasn't helped by the same medication.

An unpleasant aftertaste in the mouth has caused some people to stop taking their medication.

While some patients are grateful for a pleasant tasting liquid, a surprising number of people distrust a sweet medication and believe that the more bitter tasting medication will do them more good.

If both a husband and wife have, for example, the same sort of arthritis, a wise physician will prescribe different medications for each. The wife will have no problem taking a man's medications, but the husband, disregarding the economics involved, will usually stop taking a "woman's medicine." This is non-compliance.

Again, the size, shape and color will determine whether a medication has a psychological affect on some people, and in turn bring good compliance or poor compliance.

Many patients are reluctant to begin a treatment program. Many take the medication for a short time, and then stop if they can see no immediate results. Other patients rebel against the idea that they are dependent on a medication.

Some patients don't want to get hooked on a medication, and take the medication only sporadically.

Some people want results in a few days, or they'll stop taking their medication.

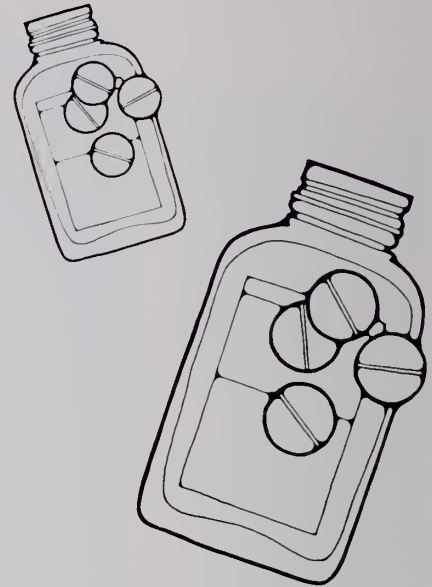
Every physician is aware that some busy people forget to take medication every four hours throughout the day. Older patients also frequently forget to take medication and are confused about what to take and when to take multiple medications. The physician can help solve this by

making a schedule for them.

The most satisfactory solution for patient compliance has been sustained action medication that needs to be taken only once or twice a day. Also effective are convenient dose packets, such as are used for oral contraceptives. Also becoming popular are transdermal patches which only need to be changed at long intervals and are acceptable to patients who object to taking anything by mouth.

While patient compliance at first seems to be a simple problem, actually there are many factors involved, and physicians must address the problems if patients are to make effective use of their medications. **OSMA**

*G. Dixon Clouse, MD, is a family practitioner in Columbus and a member of the Editorial Board of the **Bulletin** of Columbus and Franklin County.*



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National Childhood Vaccine Injury Act

Requirements for Permanent Vaccination Records and for Reporting of Selected Events After Vaccination

By National Vaccine Program, Centers for Disease Control

Health-care providers who administer certain vaccines and toxoids are required by law to record permanently certain information and to report certain events. The vaccines and toxoids to which these requirements apply are: diphtheria and tetanus toxoids and pertussis vaccine (DTP); pertussis vaccine (P); measles, mumps and rubella single-antigen vaccines and combination vaccines (MMR, MR); diphtheria and tetanus toxoids (DT); tetanus and diphtheria toxoids (Td); tetanus toxoid (T); poliovirus vaccine live, oral (OPV); and poliovirus vaccine inactivated (IPV) (Table 1). The requirements also will apply to DTP combined with inactivated poliovirus vaccine (DTP/Polio combined) if it becomes available.

Requirements for Recording

All health-care providers who administer one or more of these vaccines or toxoids are required to record in the vaccine recipient's permanent medical record (or in a permanent office log or file) the

date the vaccine was administered, the manufacturer and lot number of the vaccine, and the name, address and title of the person administering the vaccine. The term health-care provider is defined as any licensed health-care professional, organization or institution, whether private or public (including federal, state and local departments and agencies), under whose authority a specified vaccine is administered.

Table 1 and include events described in the vaccine manufacturer's package insert as contraindications to receiving additional doses of the vaccine.

Methods for Reporting

In the United States, vaccines are either publicly or privately purchased. Publicly purchased vaccines are bought with federal, state and/or local government funds. At present, the method and

Health-care providers are required to report selected post-vaccination events (Table 1) to the DHSS.

Requirements for Reporting

Health-care providers are required to report to the U.S. Department of Health and Human Services (DHHS) selected events occurring after vaccination. Reportable events are shown in

route for reporting adverse events depend on whether the vaccine administered is publicly or privately purchased. Events occurring after receipt of publicly purchased vaccines are reported through local, county and/or state

Table 1. Reportable events following vaccination

Vaccine/Toxoid	Event	Interval from Vaccination
DTP, P, DTP/Polio Combined	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Encephalopathy (or encephalitis)*	7 days
	C. Shock-collapse or hypotonic-hyporesponsive collapse*	7 days
	D. Residual seizure disorder*	(See Aids to Interpretation*)
	E. Any acute complication or sequela (including death) of above events	No limit
	F. Events in vaccinees described in manufacturer's package insert as contraindications to additional doses of vaccine†	(See package insert)
Measles, Mumps and Rubella; DT, Td, Tetanus Toxoid	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Encephalopathy (or encephalitis)*	15 days for measles, mumps, and rubella vaccines; 7 days for DT, Td, and T toxoids
	C. Residual seizure disorder*	(See Aids to Interpretation*)
	D. Any acute complication or sequela (including death) of above events	No limit
	E. Events in vaccinees described in manufacturer's package insert as contraindications to additional doses of vaccine†	(See package insert)
Oral Polio Vaccine	A. Paralytic poliomyelitis	
	— in a non-immunodeficient recipient	30 days
	— in an immunodeficient recipient	6 months
	— in a vaccine-associated community case	No limit
	B. Any acute complication or sequela (including death) of above events	No limit
Inactivated Polio Vaccine	C. Events in vaccinees described in manufacturer's package insert as contraindications to additional doses of vaccine†	(See package insert)
Inactivated Polio Vaccine	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Any acute complication or sequela (including death) of above event	No limit
	C. Events in vaccinees described in manufacturer's package insert as contraindications to additional doses of vaccine†	(See package insert)

***Aids to Interpretation:**

Shock-collapse or hypotonic-hyporesponsive collapse may be evidenced by signs or symptoms such as decrease in or loss of muscle tone, paralysis (partial or complete), hemiplegia, hemiparesis, loss of color or turning pale white or blue, unresponsiveness to environmental stimuli, depression of or loss of consciousness, prolonged sleeping with difficulty arousing, or cardiovascular or respiratory arrest.

Residual seizure disorder may be considered to have occurred if no other seizure or convulsion unaccompanied by fever or accompanied by a fever of less than 102°F occurred before the first seizure or convulsion after the administration of the vaccine involved.

AND, if in the case of measles-, mumps- or rubella-containing vaccines, the first seizure or convulsion occurred within 15 days after vaccination OR in the case of any other vaccine, the first seizure or convulsion occurred within three days after vaccination,

AND, if two or more seizures or convulsions unaccompanied by fever or accompanied by a fever of less than 102°F occurred within one year after vaccination.

The terms seizure and convulsion include grand mal, petit mal, absence, myoclonic, tonic-clonic and focal motor seizures and signs.

Encephalopathy means any significant acquired abnormality of injury to or impairment of function of the brain. Among the frequent manifestations of encephalopathy are focal and diffuse neurologic signs, increased intracranial pressure, or changes lasting at least (six) hours in level of consciousness, with or without convulsions. The neurologic signs and symptoms of encephalopathy may be temporary with complete recovery, or they may result in various degrees of permanent impairment. Signs and symptoms such as high-pitched and unusual screaming, persistent unconsolable crying, and bulging fontanel are compatible with an encephalopathy, but in and of themselves are not conclusive evidence of encephalopathy. Encephalopathy usually can be documented by slow wave activity on an electroencephalogram.

†The health-care provider must refer to the CONTRAINDICATION section of the manufacturer's package insert for each vaccine.

Table 2. Reporting of events occurring after vaccination

	Vaccine Purchased with Public Money	Vaccine Purchased with Private Money
Who Reports:	Health-care provider who administered the vaccine	Health-care provider who administered the vaccine
What Products To Report:	DTP, P, Measles, Mumps, Rubella, DT, Td, T, OPV, IPV and DTP/Polio Combined	DTP, P, Measles, Mumps, Rubella, DT, Td, T, OPV, IPV and DTP/Polio Combined
What Reactions To Report:	Events listed in Table 1 including contraindicating reactions specified in manufacturers' package inserts	Events listed in Table 1 including contraindicating reactions specified in manufacturers' package inserts
How To Report:	Initial report taken by local, county or state health department. State health department completes CDC form 71.19	Health-care provider completes Adverse Reaction Report-FDA form 1639 (include interval from vaccination, manufacturer and lot number on form)
Where To Report:	State health departments send CDC form 71.19 to: MSAEFI/IM (E05) Centers for Disease Control Atlanta, GA 30333	Completed FDA form 1639 is sent to: Food and Drug Administration (HFN-730) Rockville, MD 20857
Where To Obtain Forms:	State health departments	FDA and publications such as <i>FDA Drug Bulletin</i>

health departments to the Centers for Disease Control (CDC) on its Report of Adverse Events Following Immunization (CDC form 71.19). Events occurring after receipt of a privately purchased vaccine usually are reported directly to the Food and Drug Administration (FDA) on its Adverse Reaction Report (FDA form 1639) by the health-care provider or the manufacturer.

For the time being, these two systems for reporting adverse events are to be used to implement the requirement of Title XXI of the Public Health Service Act for reporting adverse events to DHHS (Table 2).

Reportable events occurring after receipt of a publicly purchased vaccine shall be reported to local, county, and/or state health departments through channels currently in place at those

institutions. The Report of Adverse Events Following Immunization, available at each state health department, shall be completed and sent by the state health department to CDC.

Reportable events occurring after receipt of a privately purchased vaccine shall be reported by the health-care provider directly to the FDA on the Adverse Reaction Report (FDA form 1639). Health-care providers will need to ensure that the name of the vaccine manufacturer, the lot number of the vaccine and the interval between vaccination and onset of the reaction are included on this form. FDA form 1639 can be obtained directly from Food and Drug Administration, HFN-730, Rockville, Maryland 20857. The form also is printed in *FDA Drug Bulletin*, the physician's edition of the *Physicians' Desk Reference*,

USP Drug Information for Health Care Providers, and *AMA Drug Evaluations*, and can be duplicated.

Health-care providers are requested not to provide the names and other personal identifiers of patients on FDA form 1639. Such information will be reported for publicly purchased vaccines to state and local health departments, which in turn will remove the names and personal identifiers when submitting CDC form 71.19 to CDC.

Reported by: National Vaccine Program, Office of the Assistant Secretary of Health; Office of Biologics, Office of Epidemiology and Statistics, Food and Drug Administration; Div. of Immunization, Center for Prevention Services, CDC.

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INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both additional medication, parenterally administered, and close monitoring, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions, or even death may appear as the first sign of toxicity without any previous warning. Stated differently, serious toxicity is not reliably preceded by less severe side effects.

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause-effect relationship to elevated serum theophylline concentrations may not be appreciated. Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, or pulmonary, congestive heart failure, liver disease in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12-hour or sometimes 8-hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the GI tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: **Drug-Drug:** Toxic synergism with epinephrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug load effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR 200, 300, and 450 mg Sustained Action Tablets. The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered

1. Every 24 hours in children under 12 years of age, have not been established
2. Every 12 hours in children under 6 years of age, have not been established

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are

1. Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea
2. Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions

3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias
4. Respiratory: tachypnea

5. Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis
6. Other: rash, hyperglycemia and inappropriate ADH syndrome

OVERDOSAGE Management: If potential oral overdose is established and seizure has not occurred

- A. Induce vomiting
- B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken)
- C. Administer activated charcoal

If patient is having a seizure

- A. Establish an airway
- B. Administer oxygen
- C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg
- D. Monitor vital signs, maintain blood pressure and provide adequate hydration

Post Seizure Coma

- A. Maintain airway and oxygenation
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapidly so as not to warrant consideration of dialysis, however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert.

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OHIO Medicine

Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be DOUBLE SPACED with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) should bear the figure number and author's name on back. When pertinent, the top of the photograph should be indicated. Do not clip or write on the back of the photos with a hard pencil, etc.

(b). The author should have written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

11. **CASE HISTORIES.** The *Journal* does not accept case histories.

12. **EDITORIAL ASSISTANCE.** Michelle Carlson, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Practice Patterns Often Emerge As Factors In Malpractice Lawsuits

Loss awareness calls for knowledge and understanding, alertness, sensitivity and logic — all within the growing complexities of modern medical practice.

Yet repeatedly, various medical practice patterns and behaviors emerge as factors leading to medical malpractice lawsuits. Among those which most frequently increase a physician's risk exposure are:

1. Inadequate medical records;
2. Lack of attention to practice details;
3. Breakdown in physician-patient communication;
4. Practice beyond training or expertise.

The following recommendations from Physicians Insurance Company of Ohio and the OSMA are intended as reminders to help you evaluate your own practice.

Office Medical Records

Earlier editions of the *Loss Awareness Bulletin* have focused on the vital role of adequate, meaningful and understandable medical records. Of continuing concern is the need to include all critical details in the record; to document the complexity of a difficult medical problem; and to document actions which clearly show the exercise of medical judgment.

Under no circumstances should

a medical record be altered after a physician has been notified of a potential or actual claim.

Lack of Attention to Practice Details

Lawsuits frequently are brought against physicians who are in high volume practices. Because they are extremely busy, they may inappropriately delegate functions to their staff. Physicians are, however, never excused for being too busy.

Malpractice lawsuits can arise when a physician performs an incomplete workup, treats only the symptoms, or disregards the significance of lab, X-ray or diagnostic work.

Inattention to practice details can occur when the physician is preoccupied by other problems or difficulties — personal, family or business-related — which can impact their practice.

Communication

Physicians who are sued often exhibit recurring patterns in communicating with patients and families: They fail to respond to calls and messages from patients; they fail to initiate calls to patients or families; and they fail to provide direct and understandable information.

As stressed in previous editions of the *Loss Awareness Bulletin*, what the physician does before and

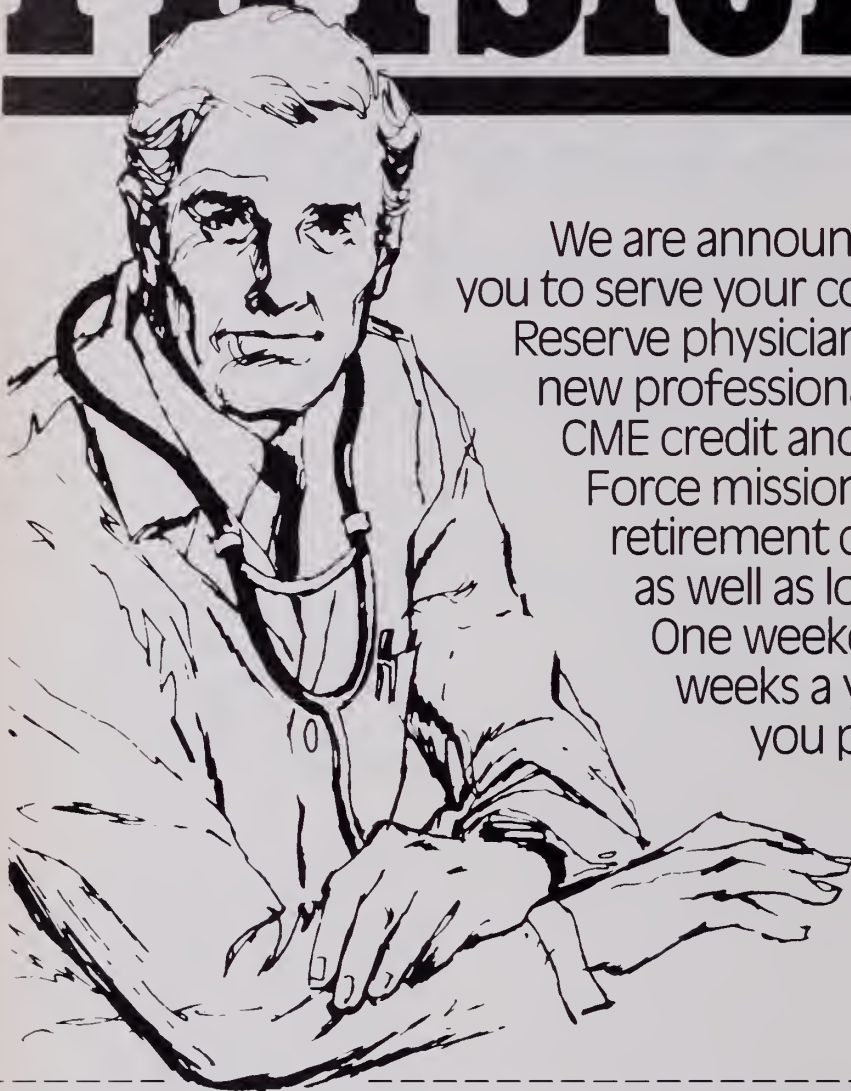
after a bad result frequently determines whether or not a patient will initiate a claim. For this reason, obtaining adequate informed consent makes good sense from a purely medical standpoint.

Practice Beyond Training or Expertise

Other behavior patterns can present pitfalls for the physician. Doctors who reflect inadequate or outmoded medical skills and who may be the most prone to lawsuits often will tolerate results which are below the current community standard. In addition to difficulties which arise from failure to keep current regarding accepted methods of treatment, another danger is presented by the failure to recognize — or the inappropriate handling of — a high-risk patient. Additional practice patterns which can lead to malpractice are inadequate and inappropriate use of consultants; deferring to patients in matters of medical judgment; and practicing without an effective referral network and adequate cross-coverage arrangements.

The next issue of Loss Awareness Bulletin will focus on the bad medical result and the price of medical oversights.

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EDITOR'S NOTE: *Financial Market Overview* is an information service for OSMA members provided by PIMS Investment Management Services, Inc., a subsidiary of Physicians Insurance Company of Ohio (PICO). Comments reflect the thoughts and opinions of that entity, and should not be construed as specific investment advice or counsel. This new feature will appear periodically in OHIO Medicine.

For the first three months of 1988, the Gross National Product (GNP) rose 3.9 percent. This is the first of many economic indicators that should lessen fears of financial forecasters that the economy will either slip into a traditional recession or grow at too rapid a pace. In view of the expected stable economic background, the future for the financial markets appears favorable for investors.

The unstable financial environment of the previous 12 months can be attributed to a

series of economic events, each having affect on the price of investment alternatives.

As the government was required to borrow in order to finance the huge federal deficit, business borrowers were literally crowded out and found it necessary to pay higher interest rates for business expansion funds. As a result, capital expenditures were sluggish, which reduced the worldwide competitiveness of U.S. companies.

This lack of competitiveness caused a large trade deficit with our global partners. Because of the negative trade balance, the dollar weakened, which increased fears of inflation and caused interest rates to rise. As the dollar fell and interest rates rose, global investors were forced to re-evaluate their positions and precipitated the stock market crash of October 1987.

Lately, interest rates have been moving upward again. At the beginning of the second quarter, the benchmark three-year U.S. Treasury bond was yielding 8.75

percent. Currently, the bond was a 9.10 percent yield, indicating a rise of 35 basis points. Other general interest rate levels have risen similarly.

Fears of inflation and faster-than-expected economic growth are the reasons most often cited for this upward trend. However, with the trade deficit showing signs of improvement and the dollar exhibiting signs of improvement, the long-term outlook is more optimistic for the stock and bond markets.

We anticipate that interest rates will level off at the current levels and that corporate profits will exceed expectations, which would be a positive surprise for the stock market. Thus, a preferred investment philosophy would reflect a fully invested position in undervalued equities for stock portfolios and a fully invested stance in three- to five-year, high quality, fixed income securities for bond investors.

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IN SUPPORT OF ROUTINE INQUIRY FOR CPR: PART I

James E. Reagan, PhD

James N. Kvale, MD

Irene Santon, RN

We submit a two-part proposal eliciting support of Ohio's physicians for the policy of Routine Inquiry for cardio-pulmonary resuscitation (CPR). In Part I we introduce the concept of Routine Inquiry. We discuss from medical, nursing and ethical viewpoints why Routine Inquiry is desirable and reasonable. In Part II we shift the focus from concept to policy. We outline important variables of forming and implementing a policy of Routine Inquiry for CPR in Ohio's hospitals. We conclude our proposal with a look at the role of law in making policy about CPR.

Introduction

Cardio-pulmonary resuscitation (CPR) is lauded as a remarkable achievement of modern medicine. It promises life and health through restoration of breathing, heartbeat and blood pressure when these functions cease.

CPR contributes to outcomes other than life and health for some patients, however. It can prolong dying and cause dysfunctional living. It can impel health-care professionals into pursuing two objectives foreign to their work: prohibiting imminent death and sustaining human suffering and indignity. Therefore CPR is a controversial as well as remarkable achievement of modern medicine. It permits both desirable and undesirable objectives of patient care and personal living.

The ambivalent character of CPR is familiar to Ohio's physicians and nurses. Health-care administrators are becoming

attuned to problems caused by CPR. This is evidenced in the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) recent requirement that accredited hospitals produce written policies about utilization of CPR as a condition for retaining accreditation. While JCAHO does not specify content of such policy, we think the requirement poses a unique opportunity for all caregivers to consider Routine Inquiry for CPR as a stipulation of policies of their hospitals.

Physician's Commentary

The rationale of a policy of Routine Inquiry for CPR is immediately visible in its name: The policy necessitates that designated agents of Ohio's hospitals initiate discussions of appropriate and inappropriate CPR with patients and/or families.

Currently in Ohio CPR is presumed a fitting intervention for all patients unless and until it is specifically ruled out in a given case. Foregoing CPR is signaled in discussion and writing a DNR (Do Not Resuscitate) order. But Ohio's patients, families physicians, nurses and hospital administrators are uncomfortable with DNR because they do not have statutory guidelines outlining consistent, permissible use of this order. Ohio's law and public policy presuppose that CPR is always fitting by not explicitly permitting selective omission of it.

A policy of Routine Inquiry for CPR effects a change of perspective. In policies of CPR inclusive of Routine Inquiry, CPR is not automatically presumed fitting for all patients. Instead, it is designated appropriate for those patients and families who request it (consent to it) following discussions of their cases with caregivers. In such discussions, CPR could be decided inappropriate or undesirable, and then ruled out. What is "routine" in Routine Inquiry is communication about CPR, and informed consent for or against it, as prerequisites for determining patients' code statuses.

The Nursing Perspective

The question of code status, of CPR or DNR, is real and pressing for nurses in contemporary health care. Nurses are often confronted with seriously ill, hospitalized patients who show

James E. Reagan, PhD, is a medical ethicist at St. Elizabeth Hospital Medical Center in Youngstown; James N. Kvale, MD, is associate director of geriatrics at the same facility; and Irene Santon, RN, is a former nursing instructor at St. Elizabeth's.

clinical signs of impending cardio-pulmonary arrest. Is CPR the appropriate response to these patients? An answer to this question follows from assessment of the health and prognosis of an individual patient. However, CPR is minimally effective in restoring health of seriously ill, hospitalized patients. It should not be instituted in every case of cardio-pulmonary arrest. Yet without Routine Inquiry into patients' code statuses, nurses must call codes and initiate CPR on all arresting patients.

It might be said that nurses do not need Routine Inquiry in implementing CPR. Rather, they need only to follow hospital policies of resuscitating all arresting patients except those with written DNR orders. These assertions imply the unspoken premise that code status has been carefully considered for all patients without the DNR order. To the contrary, however, some attending physicians have been reluctant, or cautious, or indecisive, or not anticipatory enough in their overall management and communication with patients and families to clarify code status. Some patients and/or families are rejecting the questions, too. So nurses, again, are compelled to begin CPR on all arresting patients regardless of age, health and condition, likely outcome, and patient and family wishes. Lacking informed decision-making by physicians and patients/families, nurses are left to deal with what may be termed neglected decision-making. Finally, resuscitating every arresting patient is professionally unsatisfactory insofar as nurses realize that CPR is neither clinically appropriate for or not desired by all arresting patients. Experience with CPR tells us that doing "more" for some patients does not always mean doing "better" for them.

We think that silence about code status harms the nursing role. It fosters uncertainty and increases the potential for misinterpretation about patient care therefore reducing nursing effectiveness. When the attending physician does not clarify code status with a patient or family or does not thoroughly document communication with them on the medical record, house staff, nurses and other caregivers are uncertain of how to respond, often having to make immediate decisions that do not necessarily benefit the patient. Without a clarified code status, determination of type and level of nursing intervention is hampered. Inadequate documentation concerning status often induces ambiguity because it reflects absence of an overall treatment goal. Lack of clear objectives can raise feelings of confusion, frustration and anger in nurses and other caregivers. Communication and staff morale may crumble when nurses get caught in a series of cases without clearly expressed care objectives. In catching the last breaking wave of rippling silence about code status, nurses caring for dying patients vacillate between compliance and confrontation. They must comply with implied, unwritten orders, whether these be for CPR or DNR. They must confront physicians and/or families precisely insofar as decision-making and orders are absent, unclear or poorly communicated. Nurses so distracted, so divided, not surprisingly react when such conditions persist.

How does Routine Inquiry for CPR help nurses? Routine Inquiry stipulates that a process of decision-making and a rationale regarding CPR or DNR be implemented and clarified for patients likely to suffer cardio-pulmonary arrest. Consider that the question of code status demands attention from four agents: patient, clinicians (physicians and nurses), family and hospital.

With Routine Inquiry in place, these agents have defined roles to fulfill in deciding about code status. The patient or family consent to either CPR or DNR. The physician advises the patient/family about benefits and burdens of CPR. The family functions as surrogate decision-maker when the patient cannot decide for him/her self. The hospital formulates institutional policy about CPR including provisions stipulating Routine Inquiry. Nurses benefit because Routine Inquiry assures them the coherent, consistent decision-making that underwrites both their patient care and advocacy.

Ethical Principles and Routine Inquiry

There is an echo of ethics, of ethical reasoning in our account of nurses' need for Routine Inquiry about CPR. We want to give fuller voice to the ethics of Routine Inquiry by discussing it in light of two ethical principles indispensable for patients/families and physicians: autonomy and beneficence.

"Autonomy" means a patient's (or family's) freedom to participate in medical decision-making. It includes the freedom to utilize or forego CPR. Now a patient's autonomy can be realized only when other involved parties on a case fulfill their respective duties to the patient. The attending physician must evaluate the patient's capacity and outline the prognosis to the patient and/or family. The incapacitated patient's family must consider code status according to the known wishes or best interests of the patient. The hospital must provide policy requiring such communication as well as facilitators of such policy (e.g., nurses). Given fulfillment of these duties, the patient or family can make a free, informed decision for or against CPR. Routine Inquiry for CPR satisfies the principle of autonomy by positing precisely these duties of communication and decision-making that agents on a case must fulfill. Whereas without Routine Inquiry, these duties respecting of patient autonomy are not explicitly posited, not publically enforced, and consistent respect for the principle of autonomy, and for patients, is unlikely.

The ethical principle of beneficence calls attention to clinicians' capacities to do good for patients, to achieve the most fitting managements and outcomes. Beneficence is substantiated in first doing no harm to patients, then in preventing harm being done, then in removing harm from the patients, and lastly in doing specific good actions for them. Does CPR cause harm? Prevent it? Remove it? Accomplish specific goals? Routine Inquiry satisfies the principle of beneficence in specific cases because it assures that patients, clinicians and families discuss and assess whether CPR is helpful or harmful. Whereas without Routine Inquiry, persons can simply avoid assessing the benefits and burdens of CPR. They can evade raising the question of code status altogether.

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Jazz Festival Shows That Smoke-Free Really Is Cool

*By Wendy Weinstein
and Larry Frick*

Jazz. The word brings to mind the shine of a polished instrument, of a performer's forehead slick with the perspiration that comes from an unwavering concentration. It brings to mind intimate niches where performers and audience unite in the pulse of a saxophone and trumpet jam. It brings to mind warm afternoons growing hot with music and thousands of people and sunshine. In this country, jazz also brings to mind Kool cigarettes. This link has become so tight in recent years that jazz is becoming known as kool rather than cool.

On a sunny Sunday afternoon in May some Cincinnati medical

students did their part to break the link. A crowd of 2,500 people gathered on May 15 at Seabreeze Pavilion in Cincinnati's Eden Park to enjoy a relaxing day of fresh air and jazz music. That this jazz festival was special could be seen by reading the banner proclaiming the title of this Cincinnati Bicentennial event, the "Smoke-Free Is Cool Jazz Festival."

How did a jazz festival unite with an anti-smoking campaign? This unique combination was the product of the Cincinnati chapter of Doctors Ought to Care (DOC). DOC is a national organization of physicians and medical students who work to promote health and

prevent disease in the community. The Cincinnati chapter provides information and testimony on local health issues and works with other health oriented organizations in the community. The medical students place a strong emphasis on public education and health awareness. Medical students from the University of Cincinnati give presentations in local schools on such topics as smoking, drug abuse, sexually transmitted diseases and nutrition. This program is supported by the OSMA-MSS Student-to-Student project and the Department of Family Medicine. DOC utilizes positive images and satire in its community education programs, believing that this approach is more effective than the traditional admonishments.

One of the frustrations that DOC and other groups have encountered in the fight against smoking is the massive use of the media by tobacco companies. Although cigarette advertisements have been banned from television and radio since 1970, the major tobacco companies continue to spend about two billion dollars a year on advertising. Much of this advertising is in the printed media, but the companies have found another effective method to promote their deadly product: the sponsorship of special events. The list of such events includes the Virginia Slims Tennis Tournament, the Marlboro Grand Prix Auto Race, and, of course, the Kool Jazz Festival. Also, most major league ballparks have at least one cigarette billboard, which is essentially free TV advertising. These efforts attempt to link smoking with a life of fun, excitement and vitality. Such methods are especially effective with teen-agers, who are the most likely to begin smoking.

In light of the tactics used by tobacco companies, educational talks and in-office counseling are

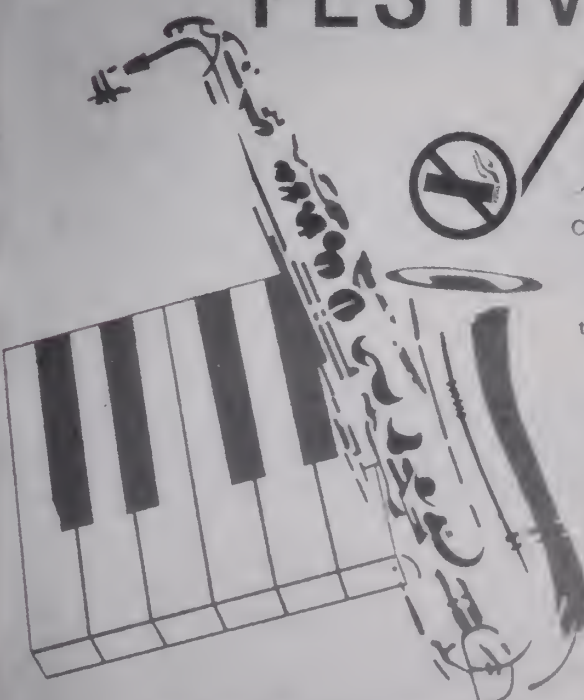
only partially effective in the anti-smoking campaign. DOC realized that to be truly effective, the same glitzy, Madison Avenue techniques used to promote smoking could also be used to promote non-smoking. This approach has been successful in Georgia with the Emphysema Slims Tennis Tournament and the Disad-Vantage Pro-Am Golf Tournament.

The concept of counter-

advertising gave birth to Cincinnati DOC's Smoke-Free Is Cool Jazz Festival, a parody of the Kool Jazz Festival which left Cincinnati this year. This festival was a natural target for anti-smoking efforts due to the traditional association of jazz with smoke-filled rooms. The event was organized by Laura Davis, a first-year medical student, and Rick Pollak, MD, an assistant professor of family medicine at

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Jazz musicians, including N.Y. saxophonist Jim Snidero, jam onstage at the Smoke-Free Is Cool Jazz Festival in Cincinnati.



U.C. and founder of Cincinnati DOC. A committee of medical students under the direction of Davis and Dr. Pollak worked with a promoter to recruit performers and publicize the event. This committee also contacted many local companies and organizations as potential sponsors. Agreeing to co-sponsor the event were the American Cancer Society, the Cincinnati Academy of Medicine's Young Physicians Committee and Merrell-Dow Pharmaceuticals. The event was also endorsed by Dr. Stanley Broadnax, Public Health Commissioner, and members of the Cincinnati City Council.

All of the hard work came to fruition on Sunday, May 15, as an estimated 2,500 people, which was more than anticipated, gathered in the city's Eden Park. The audience enjoyed performances by the U.S.

College-Conservatory of Music Jazz Septet, the Bill Cunliffe Trio, Kathy Wade, Jim Snidero, Cat City and the Afrikan-American Drum and Dance Ensemble. These talented musicians presented various styles of jazz music. Particularly intriguing was the unique Afrikan-American group which dazzled the audience with its energizing dances. Dr. Pollak and Oscar Treadwell, a popular radio jazz show host, served as masters of ceremonies for the program. DOC took advantage of the opportunity to provide educational materials about smoking and how to quit. The American Cancer Society also had an information table at the festival.

The event was a clear success. The performers presented excellent jazz music to an appreciative

audience. More importantly, the pamphlets, posters, buttons, T-shirts, and media coverage informed the audience of the dangers of smoking and the health benefits of abstaining from this dangerous habit. Most of the audience were enthusiastic about the smoke-free event and did not smoke during the festival, showing that jazz music and smoking don't have to be linked. Having received such an encouraging response in the first year, DOC will definitely be back next year to let Cincinnati and its jazz community know that smoke-free really is cool. **OSMA**

Wendy Weinstein and Larry Frick are second-year medical students at the University of Cincinnati College of Medicine.



Clothes Up and Personal: Ohio's Best-Dressed Doctor

By Michelle J. Carlson

Green gowns and sterile white masks may be appropriate garb in the operating room, but for Allan O'Brien, MD, slipping into more fashionable attire — namely tailor-made suits, dress shirts and designer ties — is decidedly more comfortable after a grueling day of surgery.

When the dapper dresser emerges, however, staff and patients in the East Liverpool surgeon's office barely bat their eyes. But that's understandable. Dr. O'Brien was, after all, recently named to the 46th Annual Best-Dressed List by the Fashion Foundation of America of Brooklyn, N.Y.

By now, Dr. O'Brien is quite used to the media attention and hype that surround his selection — he was named to the list late last December — but at the time, he says, the announcement came as a complete shock.

“(The Fashion Foundation) had

called and asked me some questions,” Dr. O'Brien recalls now — such as where he buys his clothes, and what tailors he commissions — “but I didn't know I was on the list until it came out.”

When the list was finally released to *The New York Times*, as well as the wire services, Dr. O'Brien says, “I was unbelievably tickled because it was the only thing that had ever happened like this.

“My family was quite surprised,” he continues, “especially my nephew. He was glad to have someone in the family get something like this because he's very clothes-conscious.”

While obviously pleased with his selection, Dr. O'Brien is still unsure exactly why he was chosen. “I'm not sure what criteria they use, but they do consider the appropriateness of the clothes,” he says, modestly adding that, “I think some of them noticed what I

was buying (on forays to New York City) and were impressed.”

Nor does Dr. O'Brien know where he was placed on the list — the names appeared in no particular order. However, he suspects that he was No. 10, in light of the fact that Soviet Leader Mikhail Gorbachev was mysteriously dropped from this year's list, apparently after substituting a business suit for a tuxedo during a black-tie affair during the superpower summit in Washington.

Dr. O'Brien says his special interest in clothes emerged years ago, when it became apparent that his burgeoning height — he stands 6'4" and weighs about 185 pounds — would pose certain limitations. “I've been buying clothes special for years now — since I was 18,” he says, adding that, “I'm tall, thin, and I have one shoulder that's taller than the other, so if I don't have something that looks decent, I look like a scarecrow.”

The Canadian-born physician also credits his father with influencing his smart taste in fashion: While living in Toronto, the elder O'Brien introduced his son to his own custom tailor, where the young man's appetite for fine clothes was whetted further.



Allan O'Brien, MD

Since then, Dr. O'Brien has made frequent visits to New York City tailors, and, closer to home, to men's clothing stores in Pittsburgh. For the most part, though, he avoids local retailers because of their inability to fit him properly. Machine-made suits, he explains, tend to be too long in the front and too short in the back — thus drawing further attention to his taller shoulder. Instead, Dr. O'Brien says he prefers tailor-made suits and the classic conservatism of Brooks Brothers suits.

While he tends to favor standard wool and wool/polyester blends, Dr. O'Brien still manages to bring his own sense of style to his suits. “My patterns are a little different,” he says. “An average tailor may have 1,000 different patterns, so I have quite a bit to choose from.” In that respect, however, his size is an advantage, as many of the patterns he wears — such as stripes and plaids — could not be carried well by a man of lesser stature.

For his custom-made shirts — which, in accordance with the strict rules that govern fashion, always extend one-half inch below the sleeve of his suit coat — Dr. O'Brien turns to Peck & Co.

And for his ties — he owns about 200 — Dr. O'Brien turns to a tailor in New York. A less savvy dresser might ask, why tailor-made ties? But anyone as tall as Dr. O'Brien knows that the average retail store tie falls short of fashion; his are typically 1½" to 2" longer to compensate for his height. They are also specially designed to accommodate the Windsor knots he prefers with sports jackets and the foreign-hand knot he uses with business suits.

“My clothes fit well,” he sums, “because over the years I've learned to be demanding.”

Dr. O'Brien generally shuns accessories such as hats, rings and necklaces, however he completes his look with cuff links, an invisible tie pin, and an ever-present silk handkerchief, which is tucked neatly into the breast pocket of his suit.

If all this attention to detail leaves you with the impression that Dr. O'Brien is a slave to fashion,

A Peek Inside the Doctor's Closet

As one might expect, the best-dressed doctor in America has a few preferences when it comes to choosing clothing and accessories. The following list, which includes Dr. O'Brien's favorites, makes it easy to see why he was chosen one of this year's best-dressed men in the world.

- Tailor-made suits of wool or wool/polyester blend. Colors: Blues, grays, some pinstripes and plaids.
- Custom-made dress shirts from Peck & Co. Colors: White, light blue, pale pink, yellow, some stripes.
- Tailor-made ties by Scavone of New York. Colors: Blues, grays, burgandies, some stripes.
- A silk handkerchief that coordinates with the tie, tucked neatly into the breast pocket of the suit coat.
- Handmade leather shoes by John Lobb. Color: Black.
- Black socks
- A camel hair topcoat, belted and double-breasted. Colors: Taupe, black.
- A gold tie pin
- Gold cuff links studded with a small diamond from Cartier or Tiffany.
- A gold Cartier watch
- No-no's:
 - Hats
 - Rings
 - Necklaces

fear not — at home he dresses much the same as everyone else, favoring comfortable, loose-fitting clothes such as poplin and corduroy slacks.

And while Dr. O'Brien readily admits that dressing nicely simply makes him feel better, you can also rest assured that he's not about to forsake his familiar doctor's lab coat. “I still wear a white coat (in the office) and suit my clothes (underneath) to the weather,” he says. “If it's a dismal day, I'll wear something heavier. If it's nice out, I'll wear something lightweight and blue.” OSMA

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Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur in patients given very high doses (3,900 mg) of aspirin daily; increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, if it was not possible to

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

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757 IM Busy, well-trained, BC general internist located in a dynamic community of 65,000 serving a population base of 200,000 seeks BE/BC associate partner. This successful solo practitioner seeks to eventually build a 3-4 person practice and is located near an innovative 471-bed hospital. A generous compensation and benefit package leading to full partnership with exceptional income potential and low overhead is offered. Contact: VHA Physician Placement Services, Suite 250, Brownton Place, 2000 Warrington Way, Louisville, KY 40222, Attn: Kevin Duffy, (800) 626-1857 or (502) 423-9622.

CINCINNATI, OHIO: OPHTHALMOLOGIST — Immediate position available for Board-Certified/Eligible with busy solo practitioner. Excellent salary with incentive, future partnership, temporary position available also. Send CV to Box 58445, Cincinnati, OH 45258.

CLEVELAND, SOUTH — EXCELLENT COMPENSATION offered to full-time and part-time physicians at low volume emergency department. Full malpractice insurance coverage. Benefit package available to full-time staff. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

EAST CENTRAL OHIO: Full-time staff position available in a 24,000 volume emergency department. With easy access to Pittsburgh, this community on the Ohio River offers an attractive lifestyle. Board-Certification/qualification essential. Highly competitive compensation package is offered. Contact: Charles Moore, Acute Care Specialists, 1940 West Market Street, Akron, OH 44313, (216) 867-2192.

FAMILY PHYSICIAN for busy group family practice in Akron, OH. Clinical setting including laboratory and radiology on premises. Send CV to: Peoples Medical Center, 369 S. Portage Path, Akron, OH 44320. Attn: Director.

FAMILY PHYSICIAN needed to replace retiring member of our medical staff, associated with 55-bed JCAH hospital located in north central Ohio. Income guarantee, excellent support from medical staff and hospital. Affiliation with St. Anthony Medical Center provides 24-hr. ER coverage plus opportunity for regular interaction with visiting specialists. Contact or send CV to Joe D'Ettorre, Administrator, Crestline Memorial Hospital, 291 Heiser Court, Crestline, OH 44827.

FAMILY PRACTICE — Full-time opportunities exist with this physician-owned urgent and family care center group in the Akron-Canton area. Attractive salary plus incentive package. Contact: Charles Moore, First Care, 3085 West Market Street, Akron, OH 44313, (216) 867-2192.

FAMILY PRACTITIONER needed immediately for small Eastern Ohio community located in growth-oriented Tuscarawas County. Area serviced by two hospitals, office and equipment owned by community available with very favorable financial arrangements to serious, qualified applicant. Easy access to major metropolitan areas. Please contact: Village of Midvale, P.O. Box 227, Midvale, OH 44653, (216) 339-1939, Attn: Mayor Delbert Graham.

GENERAL PHYSICIAN AND PSYCHIATRIC positions are available in Ohio, fulltime or parttime. Private prac-

tice opportunities are optional. Contact ANNASHAE CORPORATION, 6593 Wilson Mills Road, Mayfield Village, OH 44143. (216) 449-2662.

IMMEDIATE POSITION AVAILABLE in northwest Ohio hospital located in rural setting. Needed: Staff physician for emergency department. ACLS trained. Malpractice paid. Contact: Doris Marsh, Administrative Assistant, Community Hospitals of Williams County, Inc., 909 Snyder Ave., Montpelier, OH 43543, (419) 485-3154.

INTERNIST — BC/BE — Associate desired for two-member general internal medicine group in Dayton, Ohio. Guaranteed salary, benefits and partnership potential. Call (513) 223-3990 days and (513) 433-7844 evenings.

LOCUM TENENS — Opportunities available throughout the country. Work parttime or fulltime, at your convenience. Malpractice insurance, housing and transportation provided. Contact: LOCUM Medical Group, 30100 Chagrin Blvd., Cleveland, OH 44124. Or call: 1-800-752-5515 (in Ohio, 216-464-2125).

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NORTHEAST OHIO: A 250-bed community hospital is seeking experienced emergency medicine physicians to staff its 18,000 volume department. Staff and director positions available. This lakefront community offers a pleasant lifestyle with 45 minute interstate access to major metropolitan areas. Highly competitive compensation package. Contact: Charles Moore, Acute Care Specialists, 1940 West Market Street, Akron, OH 44313, (216) 867-2192.

OBERLIN, OH — 22-person multispecialty group seeks additional BC/BE family physicians, internist, OB/Gyn, dermatologist and orthopedist. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

OB/GYN: Well-established multi-specialty group near major city in Ohio seeking additional Obstetrician/Gynecologist. Excellent practice potential. Conveniently located across from Level II hospital. Competitive first-year income guarantee with eligibility for productivity bonuses beginning the first quarter. Paid malpractice in-

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OHIO, CLEVELAND. Private practice opportunities available within an urgent care setting, with fee-for-service compensation in addition to annual salary of \$75-\$80,000. Board-Certified/Eligible — FP/GP/EM/Surg/IM preferred. For more information contact Mitchell Leventhal, MD, at (216) 642-1440, or send CV, in confidence, to: 6133 Rockside Road, Suite 10, Independence, OH 44131.

OHIO, NORTHEAST/CLEVELAND: Emergency department director is being sought for 40,000+ patient volume emergency department in Greater Cleveland area. Must be Board-Certified in emergency medicine with previous appropriate administrative experience. Benefits package worth 150K, which includes retirement program, comprehensive health package, disability insurance, life insurance, professional liability, continuing education and vacation. Physician is eligible for partnership in two years. Interested individuals, please submit CV to: P.O. Box 2600, Lakewood, OH 44107.

OHIO, NORTHEAST/CLEVELAND: Emergency department physicians needed for 40,000+ patient volume hospital emergency department in Greater Cleveland area. Physician must be Board-Certified in emergency medicine, residency-trained in emergency medicine, or be Board-prepared in emergency medicine. Salary and benefits package worth \$130K. Included is liability, disability and life insurance, retirement program, vacation, continuing education and comprehensive health coverage. Full partnership eligibility in two years. Interested individuals, please submit CV to: PO Box 2600, Lakewood, OH 44107.

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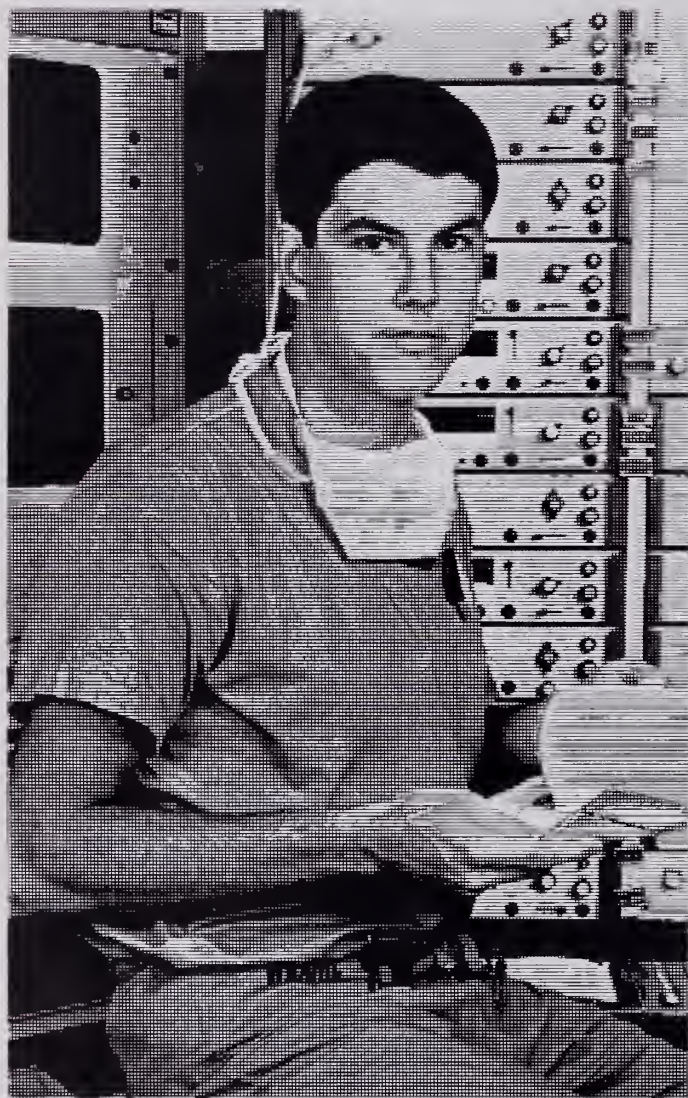
(including lasers); facility on grounds of 100+ bed hospital; terms available; will introduce. Call or write: R.L. Hirsh Associates, Ltd., 1855 Union Boulevard, Bay Shore, NY 11706 (516) 665-0439, Attn: Gregory Nizich.

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PEDIATRICS — Busy solo pediatrician looking for immediate full-time or part-time BC/BE associate. Competitive salary with malpractice. Small college town in northwest Ohio within an hour of metropolitan areas. Send CV to Box 194, c/o OHIO Medicine, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

PHYSICIANS — THE OHIO AIR NATIONAL GUARD, 178TFG, Springfield, Ohio has immediate openings for part-time family practitioners, general practitioners, pediatrics, general surgery, orthopedics, general surgery, internal medicine, and OB/GYN. In the Ohio Air National Guard you can earn a regular paycheck without taking much time away from your medical practice. In fact, most of our physicians serve just two days per month and fifteen days each year. The National Guard offers you a generous retirement plan at age 60, base exchange, commissary privileges, space available travel and term life insurance. Some of the training offered by the Air National Guard can provide you with your required Continuing Medical Education training. As an Air National Guard member, you may attend the Air Force School of Aerospace Medicine, a seven-week course of invaluable training that will entitle you to wear the wings of an Air Force Flight Surgeon. Once you've earned the wings, you'll provide medical services to the pilots and flight crew personnel in the air and on the ground. Enrich your life and career. Call us today to find out more about the opportunities waiting for you as an Ohio Air National Guard physician. Call us COLLECT at (513) 323-6704.

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SEEKING BC/BE EMERGENCY PHYSICIAN for group staffing progressive ED in Cleveland suburbs. Pleasant environment, high compensation. Send CV to Ronald Kimes, 1438 SOM Center, Cleveland, OH 44124.

SOLO PRACTITIONER WITH LARGE PRACTICE, age 64, wishes to share prac-

tice with younger man as a partner. Located in Eastern suburbs of Cleveland. Practice centered at one 300-bed hospital which is part of a not-for-profit multi-hospital health system. Excellent facilities. Reply Box 190, c/o OHIO Medicine, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

SOUTHERN OHIO — Seeking emergency department director for busy 200-bed hospital located in beautiful Ohio River Valley community. Board certification or Board eligibility in emergency medicine or primary specialty with ED experience. Excellent salary with malpractice insurance provided and benefit package available. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

TWO FP/GP MD/DO BE/BC for new FP Clinic, west suburbs, Cleveland, October 1988. Competitive salary & benefits. Partnership options after one year. No OB. Call (216) 779-9070. CV required.

WARREN, OHIO: Osteopathic manipulative therapy director interested in further developing OMT department needed for 212-bed hospital. Excellent salary/benefits package. Respond with CV or call Harriett Pascarella, Warren General Hospital, 667 Eastland Avenue SE, Warren, OH 44484, (216) 373-9788.

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OSMA

Classified Advertising

The OSMA offers classified advertising under headings designed to serve OSMA members and the medical community. Categories generally available are: employment opportunities, equipment for sale, medical office space for sale or lease, medical practices for sale, positions wanted, services and CME seminars.

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\$1.50 per word for regular ads with bold title, \$1.75 per word for ads appearing in a box. Payment for the ad must accompany advertising request. Ads must be typed. Closing date for classified ads is first day of month preceding publication.

Telephone orders for classified ads are not accepted.

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GENERAL SURGEON: 42-year-old university-trained, Board-Certified general surgeon available November 1988. CV and references available. All locations/positions in Ohio considered. Reply to Box 188, c/o OHIO Medicine, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

RECENTLY TRAINED MALE OB-GYN seeks position in Cleveland area. Expertise includes laser and ultrasound. Please respond to Box 193, c/o OHIO Medicine, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

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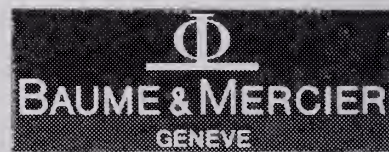
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AMA Report:

Up-To-Date News from the American Medical Association

• **Harvard's Resource-Based Study...** HCFA has granted Harvard an extension of time on its \$2.5 million Congressionally-mandated Resource-Based RVS study, which means that the report won't be delivered to the HHS Secretary until the end of this month. The AMA has learned, however, that HCFA will publicly release the study's findings shortly after receipt, instead of holding it 30 days, as they had originally planned. The new release date will enable medical organizations to proceed with their plans to review it. The study's delay is being partly attributed to a need to incorporate changes that were recommended at a major conference Harvard held in March for its study consultants.

• **Care for the Uninsured...** The proportion of Americans without health insurance has risen 25% since 1975, while the proportion of the poor and near-poor covered by Medicaid dropped during the same time period, said Harvard professor Robert Blendon in testimony before a Senate subcommittee which is holding hearings on providing adequate health insurance for the uninsured and underinsured. Blendon noted that about 33% of the nation's largest cities have no public hospital, forcing the poor to depend on the free care offered by voluntary hospitals. The AMA presented a statement for the record which called for coverage of the uninsured and underinsured by an expansion of Medicaid coverage.

• **Office Laboratories...** Proclaiming it "essential that doctors not be precluded from providing their patients with office-based clinical lab services," AMA President-Elect Alan R. Nelson, MD, testified before a House committee which is holding hearings on proposed laboratory regulation. Under a provision of OBRA '87, all clinical laboratories providing more than 5,000 tests a year would be required to meet existing independent clinical laboratory requirements, including personnel standards, starting in 1990. Physicians offices currently are exempt from this requirement. At the 1988 Annual Meeting, the AMA House of Delegates adopted a statement outlining mechanisms to assure the quality of in-office testing. It supports development of national quality assurance standards for physician office laboratories, based on factors such as proficiency testing, quality control and continuing education.

• **The Nursing Shortage...** The approaching anticipated shortage of up to a half million nurses could be alleviated by the AMA's plan to establish a new career category, the registered care technologist (RCT), said Joseph T. Painter, MD, vice chairman of the AMA's Board of Trustees, in a recent television interview. Dr. Painter explained that training RCTs to provide basic bedside care function would free nurses to concentrate on the professional aspects of nursing. At the Annual Meeting last month, the House of Delegates authorized the board to establish demonstration RCT training programs.

Unless otherwise indicated, contact the AMA by writing: 535 North Dearborn Street, Chicago, IL 60610
or by calling (312) 645-5000

AMA Report: . . . continued

• **Research Symposium on Drug Abuse...** The AMA is joining with the Association for Medical Education and Research in Substance Abuse and the National Institute on Drug Abuse to represent the AMERSA/NIDA Research Symposium on Drug Abuse, to be held 1-4 pm on October 26 in Chicago. Subjects to be covered include new research on the treatment of drug abuse, substance abuse patterns of entering medical students and genetic vulnerability to alcoholism. This symposium will precede the Ninth National Conference on the Impaired Health Professional, sponsored by the AMA in conjunction with medical, dental, pharmaceutical and veterinary organizations, and the AMA Auxiliary. Continuing education credits are available. For registration information on the Pre-Conference Research Symposium and/or the Ninth National Conference on the Impaired Health Professional, call (800) 621-8335. The registration fee for the pre-conference is \$75 for non-AMA member physicians; \$50 for AMA members and other health professionals.

• **Public Service Announcements...** During the next few months, two new AMA public service announcements (PSAs) should be turning up on network, local and cable television stations. One is on organ donation; the other deals with the homeless. "The organ donation PSA is a response to a House of Delegates resolutions at the 1987 Interim Meeting," says Shari Wolk, Division of Television, Radio and Film Services, who produced the spots. "The resolution calls on the medical profession to try to increase the number of people who consent to be organ donors." The PSA on the plight of the homeless was created to remind the public about this problem. "This PSA gives an 800 phone number for those people who would like to help but aren't sure how," says Wolk. "The call gets you a printout with the addresses in your neighborhood — churches, shelters, soup kitchens, for instance — where you can volunteer to help the homeless." The PSA on organ donation was to be released in early August. Wolk says the PSA on the homeless will be released near Thanksgiving. The AMA sent the PSAs, which were produced in both 15 and 30-second versions, to more than 500 television stations. The ABC and CBS networks are among those who have accepted them. In addition, a radio PSA on organ donation also is being distributed. The AMA produces two television PSAs every year. Previous subjects have included child abuse, drunk driving and teen suicide.

• **Non-Proprietary Nomenclature...** The USAN Council, which is sponsored jointly by the AMA, the American Pharmaceutical Association and the US Pharmacopeial Convention, Inc., will hold a one-day conference on non-proprietary nomenclature issues associated with developing and implementing non-proprietary names on a global basis. It will also provide a forum for nomenclature representatives of the pharmaceutical industry to interact directly with members of both national and international nomenclature committees. For more information on this conference, contact Gloria Stanton, Department of Medical Terminology/USAN, AMA, PO Box 10970, Chicago, Illinois 60610; (312) 645-4902.

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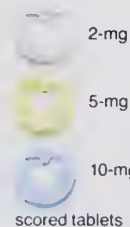
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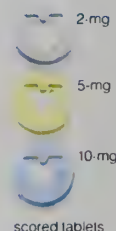
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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

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OSMA Clinical Update —

The formula for keeping up
with today's information explosion

CINCINNATI

NOVEMBER 11-13



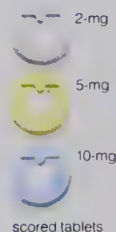
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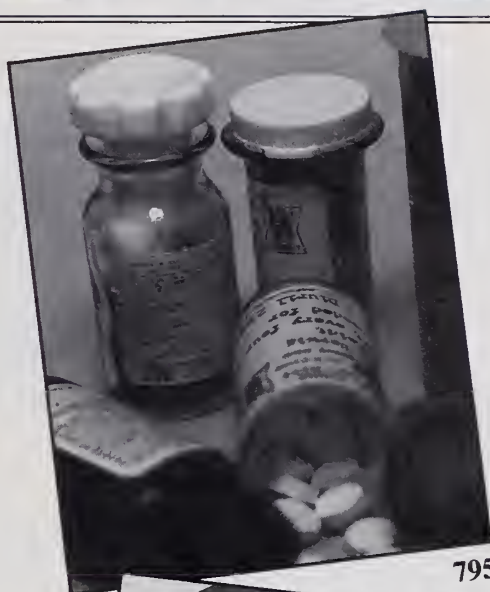
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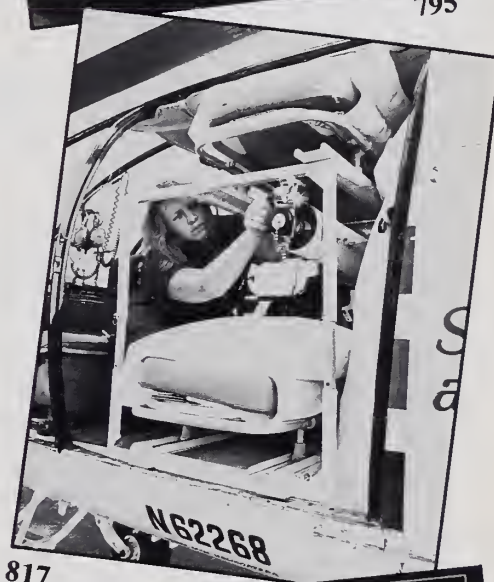
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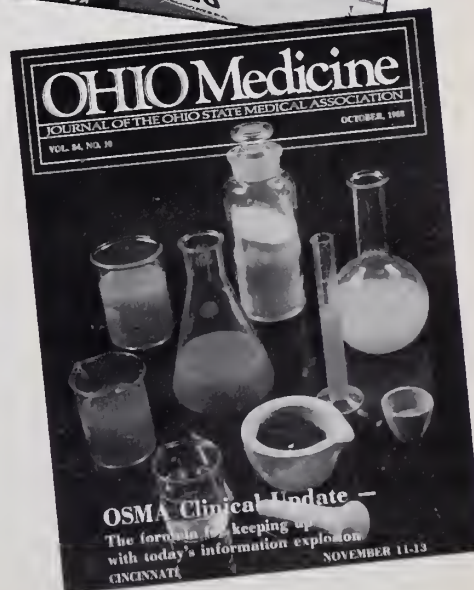
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FROM THE EDITOR



Staying on Top of the Times

How much has your field of medicine advanced in the past 10 years? The past five? The past year?

Most of you will agree that medicine is growing and changing at a rapid clip. Techniques and technology introduced just a year ago may already need some updating, some improvements. Those that existed five and 10 years ago may seem like another generation's antiques.

The point is, medicine continues to be the target of a never-ending information explosion, and as the primary practitioners in this field, it's your responsibility to keep up with as much of that new information as you possibly can.

That's why, once each year, the Ohio State Medical Association sponsors a two-day Clinical Update meeting — bringing together some of the latest facts and figures, techniques and technologies that will allow you to care more effectively for your patients.

Up until last year, the Clinical meeting always followed the Annual Meeting of the OSMA House of Delegates. Last year,

however, it was changed to a fall date, and hundreds of doctors turned out for the well-organized and informative programs that were prepared and presented by a variety of specialty societies.

This year's meeting will be November 11 through 13 at the Convention Center in Cincinnati. A program of seminars and workshops for the meeting is included in this issue. Please take a look at it, then go ahead and make your reservations. Keeping up with medicine couldn't be much simpler than that.

Next month: With new federal regulations threatening to place impossible restrictions on office laboratories by 1990, you may be wondering whether you should opt for the extra income an office lab brings in — or just scrap the idea entirely. Before you reach a decision, however, review our article "The In-Office Lab: Does It Belong in Your Practice?" It may not bring you to any quick decision — but it may clarify some of those points you've been unsure about until now.

Karen S. Edwards

A Time to Say No

By Donavin A. Baumgartner, Jr., MD



Usually after an unpleasant experience with the PRO or a particular health-care plan, physicians, with little attempt to disguise annoyance, ask a Councilor, "Why doesn't the OSMA take over the PRO?" or "Shouldn't the OSMA establish a statewide IPA?" I am sure that most of us, at one time or another, have thought that with OSMA in charge, the problems faced by the physician would be easier and true patient care issues would be addressed. The OSMA, made up of physician colleagues, could understand the reasons for certain clinical course problems that were less than satisfactory. They would be able to immediately authorize needed admissions. They would clearly see the need for added hospital days, and life for the physician, the patient and all concerned would be easier. Red tape could be eliminated and all would be well.

Unfortunately, such would not be the case. The reason is simple. Neither the PRO nor most of the health-care financing schemes are driven by a concern for quality. Furthermore, even when physicians are "in charge," they must play by the rules of non-physicians actually in control. When the government first asked for bids to become the PRO for the state, we at OSMA

took a positive stance and began to examine the position of having the OSMA do the job. There was considerable enthusiasm on Council's part for such a move initially. When the final regulations came through you could hear the minds changing with loud clicks. Clearly the regulations revealed that we would have been playing to the rules of the federal government and NOT addressing the interests of our patients. It became obvious that

"Even when physicians are 'in charge,' they must play by the rules of non-physicians actually in control."

there would be quotas and that the bottom line would be exactly that. The rules and regulations obviously were designed not to educate or improve quality of care when such deficiencies were found but to punish by means of sanctions and fines. Furthermore, definitions of such terms as "gross and flagrant" were to be liberally

applied to the point of lacking credibility. Following the move of the plaintiff attorneys, the PRO was to adopt the stance that "something went wrong therefore someone must have done something wrong." Cases were not to be investigated (even though that term is used) but to be prosecuted. With such a set of rules, it quickly became apparent to Council that the OSMA would be applying standards not based on quality of care and concern for the patient. We would have had to "come down" on our own members even in cases where the investigation revealed no evidence of wrongdoing. This realization lead to the decision by the House of Delegates NOT to apply to be the PRO. I believe that events have shown this to be a very wise decision.

The same has been true of the question of a statewide IPA. Leaving aside for the moment the overwhelming problems of organization and the wide variation in facilities, population and practice arrangements, there is the problem that any of the various health-care financial plans are, by their very nature, insurance companies and they must act

accordingly. Placing control in the hands of physicians in no way guarantees that they will be able to operate or control the insurance aspects of the plan. Many plans have found early on that costs are greater than anticipated and necessary reductions in physicians' fees or increased withholds become the order of the day. Furthermore, in an attempt to regulate costs, increasingly severe peer review measures have crept in that are designed to "alter practice patterns" (read: decrease utilization).

The picture is becoming clearer in this regard as plans in other states fold and many in Ohio are in trouble. We must remember that we are physicians and not insurance executives. We perhaps lost sight of this truth for a time in the operations of PICO, yet today changes have been made to return to the original goal. In the

case of PICO perhaps we vested too much in the non-physician management. This has been corrected and the company is now lean and mean with new policies that certainly will position it appropriately in the Ohio market.

Organized medicine is unique in its structure and operational control in that it is an amazing symbiosis between the elected physicians and the non-physician executive staff. Why it works so well is not at all clear, nevertheless the fact remains that it DOES work. The physicians establish policy while the executive staff administers this policy and handles the day-to-day operations with remarkable skill. The same must be true of any efficient insurance plan or quality assurance system. We must not lose sight of when we are physicians and when we venture too far into the "business" of health care. We must not

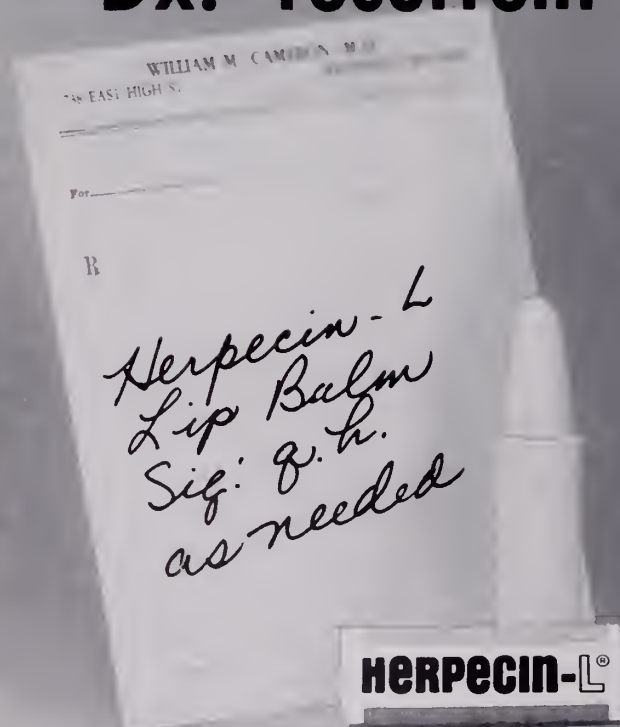
completely ignore or avoid the business aspects of medicine as much as we would perhaps wish, but when it comes to "owning" the system of PRO or IPAs there clearly is a time to say "No!!!". OSMA

Hot numbers

The Epilepsy Foundation of America's toll-free telephone service provides basic, up-to-date information on epilepsy to both the general public and medical professionals, and responds to questions on education, employment, legal matters, income support and counseling, as well as medical questions ranging from referrals to surgery and medicine.

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“Isn’t It About Time Somebody *Did* Something About It?”

By Jon E. Starr, MD

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine or the Ohio State Medical Association.

When . . .

physicians are billing for weekly or biweekly office visits and hot packs and prescribing addicting levels of multiple controlled substances on a weekly or biweekly basis for years for 5- to 20-year-old musculoligamentous/soft tissue injuries,

physicians bill for biweekly exams, phonophoresis, norflex injections, and prescribe 60-100 Talwin 50 plus 60-100 Valium 10mg per month continuously five years after a laceration of a fingertip,

70 percent of patients having back surgeries for industrial injuries are certified by their surgeons to be disabled more than two years after the surgery,

a surgeon will amputate a patient’s leg for pain and claim that the amputation was curative even though the patient was on addicting levels of Percodan months before and after the “curative” amputation,

a surgeon does nine back surgeries in nine years, none of which even momentarily relieved the patient’s suffering,

a surgeon does four wrist surgeries in two years for pain on an initial sprain and now wants to do more because the patient still has pain,

physicians are willing to write that the patient’s present coronary artery disease is due to a 7-year-old shoulder bruise,

physicians are willing to write that a 4-year-old lumbar muscle strain irritated an ependymoma at D7 resulting in paralysis,

physicians perform CT/myelograms on a yearly basis for seven years, all of which are normal, without any clinical evidence of need or change in symptomatology,

a cardiologist does monthly stress tests on a patient for three years after an MI and then states that the 52-year-old patient is totally disabled due to progressive and unstable angina and “consideration may need to be given to possible cardiac catheterization *sometime in the future*,”

physicians continue to give injections of sodium thiosalicylate on a weekly basis for seven to 10 years for 20-year-old muscle strains,

physicians continue to give weekly injections of norflex or depomedrol or lidocaine or vistaril or ACTH or nubain or dilaudid for three to 10 years for 3- to 20-year-old muscle strains,

physicians are willing to compromise not only their own credibility but in so doing destroy the credibility of the profession by opinions that would result in staff charges of incompetence if rendered in a hospital setting,

an internist does monthly pulmonary function studies for years reported as abnormal on a 76-year-old patient with silicosis and then states that the patient is totally disabled, after which another physician documents normal pulmonary function studies,

physicians hospitalize patients for three to four weeks for drug detox because of medications they have prescribed for muscle strains, then prescribe those same medications on discharge, and repeat that process twice a year for three to four years,

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Please note that the above citations are not imagined scenarios, but are documented occurrences in the real world . . .

a surgeon bills over \$6,000 for arthroscopy and simple medial meniscectomy,

a physician bills the patient his UCR, then retroactively increases it by 30 percent to 50 percent when he discovers that it is covered by insurance,

physicians bill for \$200-\$300 of laboratory tests per month for months, all normal, and state on the bill that the tests were necessary because the patient was being prescribed an NSAID during that time,

60 percent to 70 percent of patients with chronic benign pain syndrome are on addicting combinations of controlled substances,

the licensing board has received notice in 1979 and ongoing evidence since 1986 of substandard/crippling surgery by a physician in Ohio, has concluded their accumulation of evidence in 1987, and as of January 1988 has not reviewed that material to determine whether charges should be filed,

a general practitioner barred from participation in Medicare for questionable quality of care received seven to eight times the state average income for physicians in 1986 and 1987 for care of industrial injuries, and as of January 1988 the licensing board had yet to even start an investigation,

and when

physicians and organized medicine

have for years spent enormous amounts of time and money protesting the intrusion of third-party payors on their freedoms of practice, yet have been for whatever excuse unwilling and/or afraid to **"EXPOSE THOSE PHYSICIANS DEFICIENT IN CHARACTER OR COMPETENCE, OR WHO ENGAGE IN FRAUD OR DECEPTION"***,

should we really be surprised that those same third-party payors, in the vacuum of inaction by our profession on issues that we should be addressing, decided that it was about time that *someone* did something about it?

The result? Those very restrictions we protest are applied to *all* of the profession because we have not assumed our responsibility to expose and police those *few* entrepreneurs/incompetents who practice "medicine" as documented above. Please note that the above citations are *not* imagined scenarios, but are documented occurrences in the real world of medicine in Ohio, nor are they isolated cases.

While I will be the first to admit that many of the procedures and policies of third-party payors may delay instead of simply assure the patient quality care, in my opinion if we as a profession are to regain or retain our stature and credibility in the realm of quality care and medical economics, both in the eyes of the patient as well as the third-party payor, it's about time we become willing to assume

the responsibilities predicated by that claimed credibility. While such action on the part of the profession carries no guarantee of lessening third-party restrictions, lack of such action is a virtual guarantee of further action by the insurance industry.

*Jon E. Starr, MD, is
Chief Medical Adviser for the
Industrial Commission of Ohio,
Ohio Bureau Workers'
Compensation*

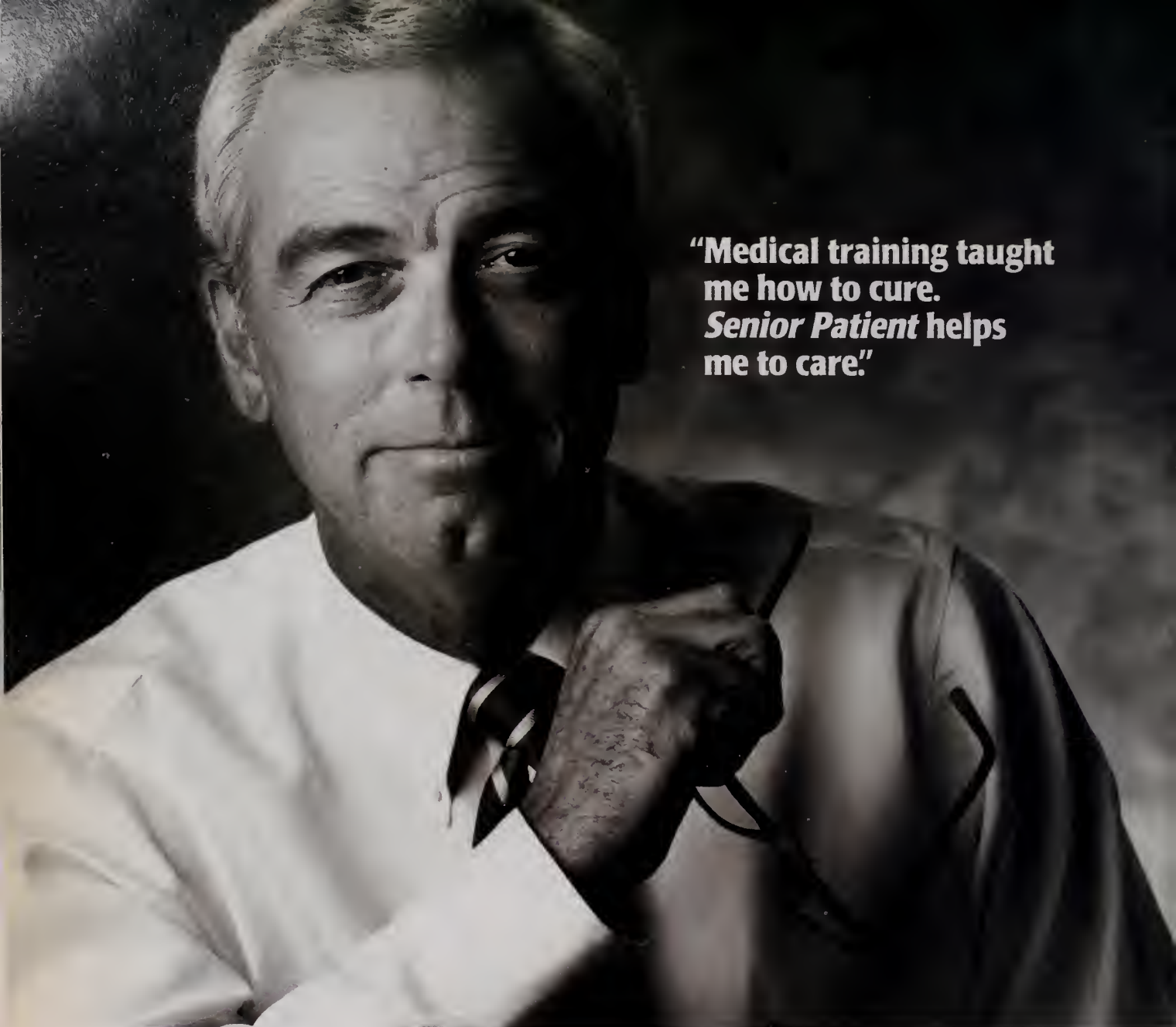
*If you don't recognize it, look it up.

WHY AMA?

While the AMA endorses competition in health care delivery that eliminates excess cost without compromising quality, the AMA actively opposes any legislative initiatives that would reduce quality of medical services. AMA leadership in making high quality, cost effective health care available to the American public: it's one more good reason why you should be a part of the AMA.

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LETTERS TO THE EDITOR

Reproduction technology: What's really going on?

To the Editor:

I just recently came across the March, 1988 issue of *OHIO Medicine* and I read with interest your article on "Reproduction Technology." I feel that much was covered in the article. However, it is obvious that there was not much research done to determine what is really going on in Ohio in these types of issues. For example, when surrogate mothering was being discussed, it was stated that "There is the East Coast physician who performs surrogate implants by transplanting the natural mothers fertilized egg into another woman's uterus." I would like to point out that the first birth in the world from this type of surrogating actually occurred through the procedure being done at the Mt. Sinai Medical Center. There may have been some confusion since the husband of the couple was an East Coast physician. Indeed, to our knowledge there have been less than 10 such ongoing pregnancies, four of which have been conceived through the Mt. Sinai Medical Center of Cleveland program.

Another area that was also misrepresented was the area of sex pre-selection. At the Mt. Sinai Medical Center and at some other centers that I am aware of, sex pre-selection has indeed been offered for more than three years. At Mt. Sinai Medical Center for example, we do offer sex pre-selection for enhancing the odds for a female baby. The only reason we do not offer pre-selection for male children is that Dr. Erickson has patented the method and we feel it is not ethical to patent such a method and, therefore, we do not want to participate with him in his method.

I feel that the topic of "Reproduction Technology" is certainly a timely one. I would,

however, hope that in the future more accurate research be done before producing an article on such an important subject. It is this partial information that results in much inappropriate legislation that upsets all of us. I feel that the *Journal of the Ohio State Medical Association* should certainly not further such partial information.

I would be interested in your comments regarding the above article. Thank you for your prompt attention to this matter.

Sincerely,
James M. Goldfarb, MD

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

Experimental AIDS drugs — worthless?

Saying it would be a “tragedy” to allow experimental drugs to be made widely available before they were thoroughly tested, Frank E. Young, Commissioner of the Food and Drug Administration, hinted in a hearing before the Senate Labor and Human Resources Committee that most experimental AIDS drugs would be shown to be ineffective or dangerous.

“While we do not want to deprive people of hope, we also do not want to generate or perpetuate the false hope of a worthless product,” he said.

Young predicted that by 1995 tests of an estimated 520 substances would result in only

five or six successful products, and by the year 2000, only 11 compounds might come out of a total of 720 substances tested.

His comments, however, were in response to criticism recently levied by gay rights activist groups who believe that the FDA is moving too slowly in making experimental drugs available to AIDS patients.

“If there is even a chance that a candidate AIDS therapy could be useful — that it might buy a few months of extra life for certain people with AIDS — we cannot afford to ignore it,” says Barry Gingell, MD, director of medical information for the Gay Men’s Health Crisis in New York.



Stroke incidence once again on rise

A decline in the incidence of strokes, first marked during the 1950s and ’60s, and which had stabilized during the 1970s, is once again on the rise.

From 1980 to 1984, the average incidence rate for strokes was 15 percent higher than the previous five years, says Joseph Broderick, MD, who recently presented a report on stroke incidence to the American Academy of Neurology.

The increase may be due to wider use of computerized tomography scans of the brain, which help diagnose mild strokes that might have previously passed unnoticed. Further study should reveal, however, whether the increase in stroke incidence is due to an increase in strokes, or an increase in detection.

The rise in stroke incidence was most notable in women, age 85 or older, Dr. Broderick notes — a trend that bears watching, he adds, as America’s population continues to age.

U.S. hospitals . . . will they survive?

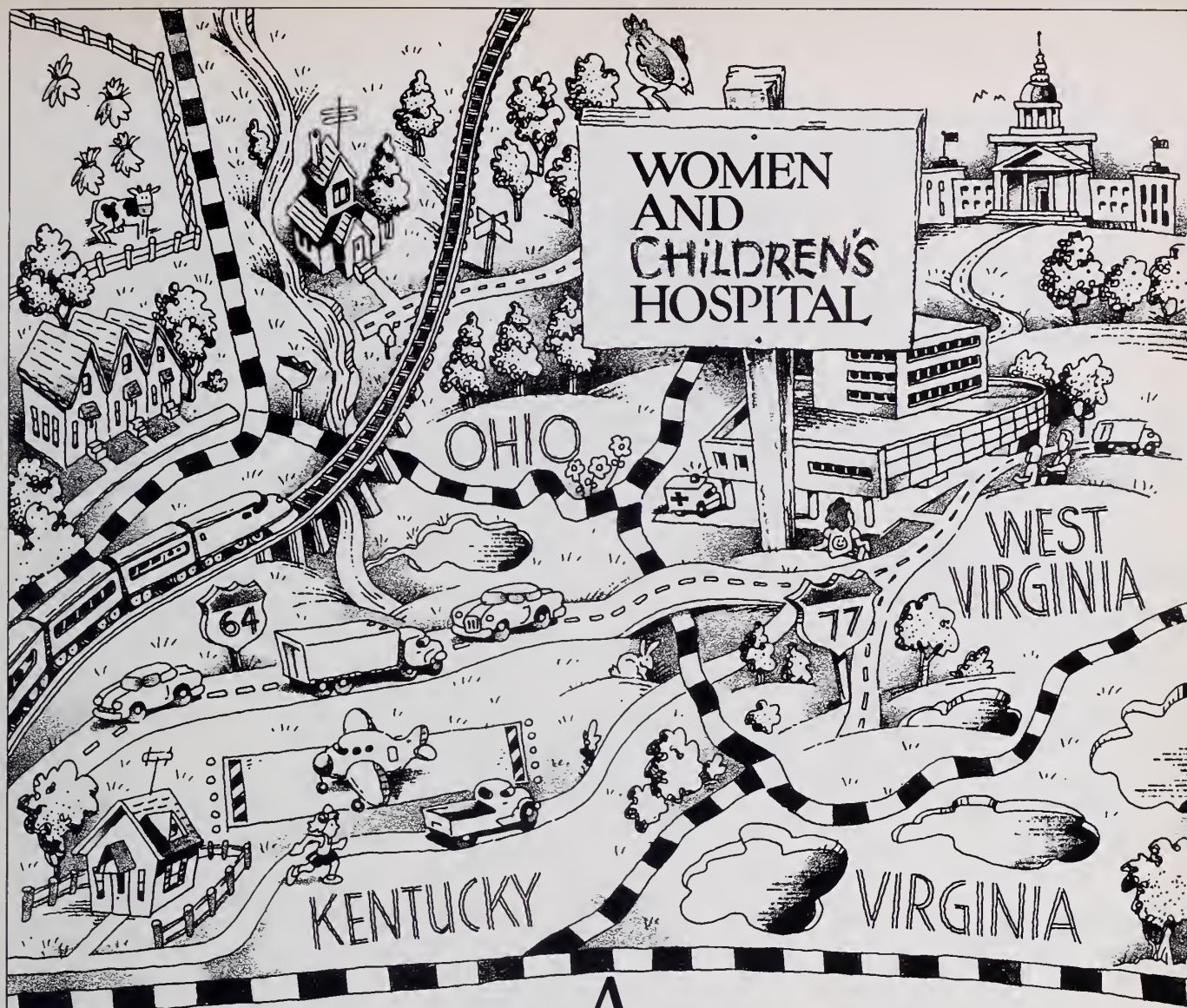
Survival appears to be the key word for today’s hospitals as 43% of the hospital executives responding to a U.S. hospital survey on the future of health care indicated that their institutions were at risk of failure. Further, 78% of the respondents believe that 5% or more of the hospitals in the country would close between 1986 and 1991.

Presidents of medical staffs, however, were even more pessimistic about the future health of this country’s hospitals. According to the same survey, 22% of physicians believe that 15% or more of the hospitals will close, and over half indicated that 10% or more of the hospitals will close.

The greatest confidence was expressed by inner-city and urban hospitals — “most likely from the

fact that these hospitals are larger, tax-exempt, non-government and members of multi-hospital systems,” the report states. Rural hospitals, on the other hand, and suburban hospitals felt the most vulnerable.

As for hospital ownership, hospitals owned by religious organizations express the greatest increase in vulnerability to failure over 1986, but there is also a surprising increase in the number of hospital executives from investor-owned hospitals that anticipate failure as falling earnings and sales of facilities become more common. Overall, government-owned hospitals continue to predict the highest rate of closings, again the majority of which (72%) have fewer than 100 beds.



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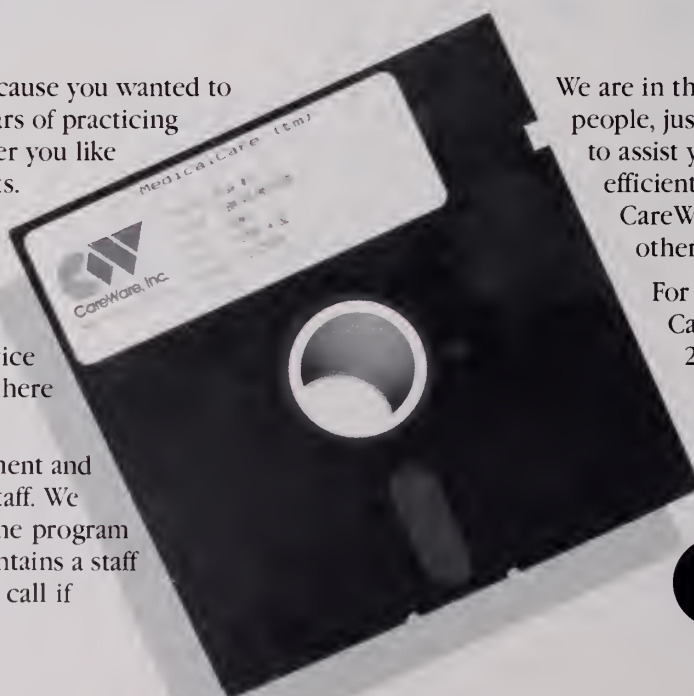
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COLLEAGUES



Left: Helmut S. Schmidt, MD, distinguished service in the field of sleep disorders.

Right: Ellen Buerk, MD, named to National Board's Test Committees.

ANTOINETTE EATON, MD, a Columbus pediatrician, has received national recognition from the American Academy of Pediatrics for her continued efforts to upgrade health care for children . . . **PAUL A. WEBBER, MD**, Upper Arlington, has been named chairman of the department of ophthalmology at Ohio State University College of Medicine . . . **PETER A. MARROCCO, MD**, Cincinnati, has been named chairman of the Daniel Drake Society. The organization annually recognizes a living physician who has brought distinction to Cincinnati's medical community or to themselves . . . **VICTOR S. ROTH, MD**, Bedford, has been appointed medical director of MEDNET'S Rockside clinic . . . **PAUL SCHILDT, MD**, Lakewood, has received the Guterus Award from the American Urological Association for his outstanding contributions to the arts and sciences of urology . . . **BYRON GUSTIN, MD**, Cincinnati, has been named medical director of the cardiac catheterization lab at Mercy Hospital . . . **ELLEN BUERK, MD**, Oxford, has been named by the National Board of Medical Examiners and the Federation of State Medical Boards to the National Board's Test Committees for the Federation Licensing Examination (FLEX) . . . **CHARLES B. PAYNE, JR., MD**, Dayton, has been elected president of the American Lung Association of the Miami Valley Board of Directors . . . **RICHARD PAYNE, MD**, and **GERALD POWERS, MD**, both of Cincinnati, have been recognized as outstanding black achievers by the Greater Cincinnati YMCA Black Achievers Program . . . **ALTER G. PEERLESS, MD**, Cincinnati, has been appointed medical director of the department of otolaryngology at Jewish Hospital . . . **BERNADINE HEALY, MD**, Cleveland, has been elected president of the American Heart Association . . .

WILLIAM MILLHON, MD, Westerville, has been elected chairman of the board of trustees at Peer Review Systems, Inc. . . . The Cleveland Society of Obstetricians and Gynecologists recently elected officers for 1988-89. They are as follows: **CHARLES BAILIN, MD**, Euclid, President; **MICHAEL GYVES, MD**, Cleveland, President-Elect; **GITA GIDWANI, MD**, Fairview Park, Secretary; and **BRADLEY DENNIS, MD**, Cleveland, Treasurer . . . **RICHARD A. LANGSDORF, MD**, Massillon, has been elected chief of staff of Doctors Hospital . . . **W. DAVID DAWDY, MD**, Westerville, has been elected president of Children's Hospital's medical staff for 1988 . . . **WILLIAM A. SPOHN, MD**, Dayton, has been elected to serve on the American Lung Association of the Miami Valley board of directors . . . **THOMAS E. FOX, MD**, Mason, has been elected president of the American Heart Association's southwestern Ohio chapter . . . **MARTIN M. DEBEUKLEAER, MD**, Toledo, has been installed as chief of staff of the Medical College Hospitals . . . **R. DONALD WOODSON, MD**, Port Clinton, has received a three-year appointment as cancer liaison physician for the cancer program at H.B. Magruder Hospital . . . **HELMUT S. SCHMIDT, MD**, Columbus, has received the Nathaniel Kleitman Distinguished Service Award from the American Sleep Disorders Association. The award is given to honor service in the field of sleep research and sleep disorders medicine . . . **STEPHEN ULRICH, MD**, New Lexington, has been appointed county health commissioner of Perry County following the resignation of **RALPH HERENDEEN, JR., MD** . . . **JOHN W. NURRE, II, MD**, Cincinnati, has received two awards while serving as chief resident of the department of otolaryngology and head and neck surgery at the University

of Cincinnati Medical Center. Dr. Nurre was awarded the 1988 Alter Peerless Memorial Award, which honors the chief resident who best exemplifies the qualities of a physician and teacher, and the first Gerson Lowenthal Award for outstanding microsurgical skills in ear surgery . . . **RALPH SCOTT, MD**, Cincinnati, has received a three-year appointment as cancer liaison physician at Christ Hospital.

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moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

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- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
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- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
 - As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
 - Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
 - Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
- Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes.
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OHIO MEDI-SCENE

Medicaid tips . . . memo mania . . . Ohio's newsmakers . . . county society roster changes . . . medical direction liability clarified . . . post-polio syndrome . . .

Medicaid tips

The Ohio Department of Human Services makes changes in the drug formulary quarterly. Most of the additions and the deletions are based on recommendations presented by the Pharmacy and Therapeutics Committee. The committee is comprised of Janet Bixel, MD; Charles May, DO; James Visconti, PhD; Suzanne Eastman, RPh, MS; Mary Ann Waltenbaugh, RN; and Robert P. Reid, RPh, Chairman.

For your information the following changes will appear in the November 1, 1988 update.

Additions:

Baclofen 10mg, 20mg (Generic of Lioresal); Bicitra;
Chlorphen/P-EPH/P-TOL (Generic of Comhist LA);
Chlorphen/P-PROP/Phenindamine (Generic of Nalamine);
Chlorphen/Pseudo/Aceta (Generic of Singlet); Citrucel Regular; Daraprim 25mg; Dermuspray; Desipramine 150mg; Disopyramide CR 150mg; Doxepin Oral Conc; Erythromycin Ethylsucc/Sulfa (Generic of Pediazole); Ethchlorvynol (Generic of Placidyl); Fedahist Timecaps, Ped Exp Drops; Fenoprofen 200mg, 300mg, 600mg (Generic of Nalfon); Furosemide Soln 40mg/5ml; Glutose 25gm; Hyoscyamine 0.125mg (Generic



of Levsin); Hytrin 10mg; Kaolin Pectin PG; Levothyroxine 0.0125mg, 0.025mg, 0.05mg, 0.075mg, 0.125mg, 0.175mg; Lopid 600mg; Lorelco 500mg; Loxapine 5mg, 10mg, 25mg, 50mg (Generic of Loxitane); Maxzide-25; Megestrol 20mg; Metaproterenol 10mg, 20mg (Generic of Alupent and Metaprel); Methylphenidate SR 20mg; Microx; N.E.E. 1/35; Nelova 10/11; Novantrone Inj; Oxsoralen Ultra; Oxybutynin (Generic of Ditropan); Pancrease MT-4, MT-10, MT-16; Pediotic; Polycitras; Pramoxine HC (Generic of Proctofoam HC); Synthroid 0.112mg, 0.175mg; Terazol Vag Tabs, Cream; Trazodone 150mg.

Deletions due to state MAC:
Bentyl Syrup, Dimetane DC, Dimetane DX, Dimetapp Liquid, Dimetapp Extentabs,

Lasix Oral Soln, Pyridium 100mg and 200mg, Stelazine 1mg.

Deletions due to discontinuation:

Some Cleocin Inj; Fiorinal #1 and #2; Medrol 7gm Tubes; Ortho Novum 10/11 Refills; Oxsoralen Caps; Pamine 2.5mg 500's; Provera 10mg 10's; Seffin 10gm.

The maximum allowable prescribing quantity has been raised on these medications which we find are most often prescribed for chronic maintenance medications. Once the patient is stabilized, physicians will be able to write for quantities up to a 90-day supply in most cases.

Janet Bixel, MD, your OSMA representative on the P & T Committee, will keep you informed of changes in the Ohio Medicaid Drug Formulary. — Robert P. Reid, RPh

OHIO MEDI-SCENE

Memo Mania

When you first enter Dr. Charles Johnson's office, the first thing you look for are his memos. You know, *the* memos — the ones with the different facial expressions and the funny sayings, the ones that were recently the focus of a story in *The Columbus Dispatch*.

But they're nowhere in sight. In fact, Dr. Johnson must rummage through the clutter behind his desk for a moment in order to find them — but not before he takes a minute to demonstrate his newest toy.

"This one is my favorite," says the pediatrician, picking up a bright green plastic frog with yellow eyeglasses from his desk. With a flourish, he pulls the frog's string, then revels in its antics: As the frog's legs beat wildly, a red bug dangling from its mouth slowly makes its way upward. It stops at the frog's mouth, then suddenly is gulped down. Dr. Johnson lets out a laugh, then turns his attention back to locating the memos.

"... if you want to get your message across to people, you have to start getting creative."

"Ah, here we are," he says, as he steers you to a nearby table. He spreads out six tablets of memos — five with photos of himself and a variety of sayings, one with hand-drawn self portraits — and

begins to explain.

Years ago, says Dr. Johnson, who is the director of the Child Advocacy Team at Children's Hospital — a team that examines and diagnoses child abuse patients — he was required to update his hospital photo I.D. The photographer asked him to smile. "I told him, 'I don't want to smile. I don't feel like it,'" Dr. Johnson recalls. "So I kind of frowned. Then I did a big cheesecake smile just to make him happy."

One thing led to another, and Dr. Johnson found himself asking the photographer to take three more photos of himself — while sporting various expressions. The photos eventually wound up on his personal stationery, complete with sayings such as "Such a mensch" and "I can't believe it" to indicate his mood.

"We have a communication overload now," says Dr. Johnson, explaining his reason for creating the stationery. "I get three inches of memos every day . . . so if you want to get your message across to people, you have to start getting creative."

To illustrate his point, Dr. Johnson pulls out one of the memos that is standard around Children's Hospital. It's white and blue, and well, nondescript. Exactly, Dr. Johnson says. "You're unlikely to pay attention to these, so I tend not to use them," he says. "It's not a bad design, but everyone gets them."

Dr. Johnson's memos, on the other hand, are not only likely to

garner attention, they're apt to elicit a response. Depending on the situation (and his mood), Dr. Johnson may send you a memo that features:

- The surprised, pop-eyed Dr. Johnson, congratulating people on a job well-done.
- The Dr. Johnson with the cheesecake smile, exclaiming "Nice going" or "More of the same."
- The expressionless Dr. Johnson, indicating "Ho hum" or "Big deal."
- The doubtful Dr. Johnson, who can't believe what's going on.
- The scowling Dr. Johnson, used to show his anger or displeasure with a given situation.

Of the five, Dr. Johnson says he uses the surprised and cheesecake photos the most. Rarely, he says, does he send the expressionless or doubtful memos. "Very seldom am I in the middle," he explains. "It's not my personality."

Judging from the thickness of one pad, the scowling memos don't see much use, either.

(Though Dr. Johnson admits that he's about to dash one off to the hospital's supply department. It seems that he's been waiting for three weeks for a battery for a camera he uses to photograph child abuse victims, and well, he's not pleased.)

In addition to the memos with his photo, Dr. Johnson also has a pad of generic stationery with 15 thumbnail-size sketches of himself at the bottom. They show him smiling, frowning, winking and sticking his tongue out. One even



☐ **WONDERFUL**

☐ **YES**

☐ **More of the same**

☐ **Such a mensch!**

☐ **NICE GOING**

☐ **THANKS**

☐ **other**

Above: Dr. Charles Johnson has merely to check the right box to let his highly-creative, all-purpose memo get his message across. His photo, left, leaves no doubt in the receiver's mind who the message is from!

has fangs.

"I use these for everyday memos," he says. "All I have to do is circle the expression that pertains to the situation."

If Dr. Johnson receives a memo and doesn't have much time to respond, he's likely to mark it with his special thumbs up/thumbs down stamp, or possibly with a likeness of his smiling face. He might also, like he demonstrated for his visitor, adorn the memo with red hearts, flowers and other assorted stickers.

"If you use a little humor," he says, "it's hard for someone to react with resistance. It's just trying to be clever."

Clever is what some might call his signature — practically everything that crosses his desk is signed with his own special-blend green ink.

"I brew my own ink," Dr. Johnson says. "Ball pen to me has no personality. Because it's my own ink, I know it's my signature."

Seriously, though, where does one find ink that is four parts green to one part black? "In the ink brew department," he laughs,

jumping up to open a drawer that reveals bottles of various inks.

Actually, Dr. Johnson does a lot of jumping around. He's already on his feet again, asking if the reporter would like to see his special lab coats.

One, which he calls his "working" coat (for when he prowls the hospital corridors and meets with colleagues) is embroidered with flowers of his own design. The second coat, which he wears around children, is adorned with numerous buttons. It's pockets are filled with a plastic doll, a squeaking rat and two finger puppets.

"One advantage of being a pediatrician is that I get to play with toys," he winks.

When you ask him about the flowered tie he is wearing (which, by the way, clashes horribly with his striped shirt and red striped suspenders), he admits that, "When I go to court, obviously, I don't wear a bright tie. I wear a conservative, patternless tie," he says, pulling out a drab, brown tie, which — you might have guessed by now — is about two to three inches wider than your everyday tie.

Yes, it's true: the chuckles, laughs and guffaws just seem to keep coming when Dr. Johnson is around.

But why, some of his colleagues might ask, is all this necessary? Why all the toys, the buttons, the outrageous memos, the ugly ties? Why not just sit back and practice medicine like everyone else?

Well, to hear Dr. Johnson tell it, his less-than-conventional methods are probably a reflection of both his personality and his desire to bring some levity to an otherwise somber situation — that of diagnosing possible child abuse victims.

First, "I'm kind of artsy craftsy," Dr. Johnson says, as he points around his office to some framed logos, an abstract painting and a piece of stained glass — all his creations.

The author of a book of cartoons (some of which adorn the hall outside his office), Dr. Johnson says he's comfortable combining art and medicine because the latter allows him the freedom to pursue whatever art medium he desires. "Medicine allows me to do whatever I want

OHIO MEDI-SCENE

Memo Mania . . . continued

with my art," he explains, "and I don't have to care if anyone likes it." In fact, Dr. Johnson's artistic bent is so great, that he admits that, "When I retire, if I ever do, that's what I'll do — go back to school and get a degree and teach art."

The seriousness of his job has also had a hand in drawing out his lighter side.

"In the beginning," he says, "I was upset by the cases I saw. But you have to be objective or you can't serve the family or the patient. We use a lot of humor. At least, that's the way I deal with it."

"We use a lot of humor. At least, that's the way I deal with it. Some may think that's macabre but . . . this is reality."

"Some may think that's macabre," he continues, "but I'm not dealing with something rare. This is reality. You can't say you're dealing with something that never happens."

And if it takes a little humor to get over the rough spots, Dr. Johnson says, then so be it.

"Most physicians are involved in quote, 'serious business,' " Dr. Johnson says, "but it's necessary in this business to interrupt things by being a little light-hearted." — Michelle J. Carlson

Ohio's newsmakers

• **Dr. Heimlich's First Aid Video . . .** The Ohio physician who taught the nation how to handle choking emergencies is now taking his first aid advice into the home. This month, a 36-minute home video, "Henry Heimlich's Home First Aid," is available to those who want a handy reference for home emergencies close at hand. The video demonstrates how to handle a variety of common emergencies, providing simple, useful instructions for everything from poisoning to burns, bleeding, bee stings and animal bites. Dr. Heimlich conceived the idea for a home video about two years ago, when he learned that a 5-year-old had saved the life of a 6-year-old by using the Heimlich Manuever, which the youth had seen demonstrated on television. "I realized," says Dr. Heimlich in an article in the *Cincinnati Post*, "that many medical situations can be broken down into 1-2-3 simplicity to help enable people to react confidently and calmly." The video is available in VHS and Beta, with a suggested retail price of \$19.95.

• **Clonidine and PMS . . .** William A. Price, MD, a psychiatrist and faculty member at Northeastern Ohio Universities College of Medicine, reports the anti-hypertensive drug, clonidine, may be useful in treating Premenstrual Syndrome. In a paper recently presented at a National Institute of Mental Health Conference in Pittsburgh, Dr. Price said the preliminary study, based on 18 women with

moderate to severe PMS, found clonidine superior to a placebo in reducing anxiety, tension and hostility and in reducing the women's self-reported abdominal cramping, backache and nausea. Low doses and the short duration over which the drug was administered limited the side effects, he noted. In an earlier paper, Dr. Price and A. James Giannini, MD, reported on the use of clonidine in blocking symptoms of opiate withdrawal, and noted that several symptoms of PMS are similar to those of opiate withdrawal.

• **Rehabilitation Engineering Center . . .** Case Western Reserve University will establish a national Rehabilitation Engineering Center for Functional Electrical Stimulation in Cleveland with a \$2.5 million grant, awarded over the next five years. The center will be the only federally designated site dedicated entirely to the research, development, teaching and clinical application of functional electrical stimulation for the treatment of paralysis — offering new hope to persons handicapped by head injury, spinal cord injury, cerebral palsy and scoliosis. Specifically, the center's goals are: 1) To develop, test, implement and monitor clinical systems using FES technology; 2) to train and disseminate information to researchers, clinicians and rehabilitation professionals in the use of FES systems for handicapped persons; 3) to transfer technology to industry; and 4) to publish new

scientific research articles on FES advancements. Since the 1960s, researchers and clinicians at CWRU have studied the basic mechanisms involved in safe, selective and efficient electrical stimulation of muscles. These studies have led to the

development of new procedures to control muscles, including implantable electrodes.

"The scientific and engineering aspects of FES technology are exciting," says P. Hunter Peckham, professor of biomedical engineering and director of the proposed center.

"It is the application of this technology — the human element of potentially enriched lives — that makes the research especially gratifying.

Funding for this project will enable us to continue toward our goal of making FES technology an internationally accepted and available treatment for the handicapped." — *Karen Edwards*

Medical direction liability clarified

One of the key components of our emergency medical services system is physician medical direction. Many of us currently perform this vital service, either as medical director for local squads or as emergency physicians giving directions by radio to incoming squads. Numerous questions have arisen over the past few years concerning the malpractice liability for these activities. As former medical director of the Ohio EMS Agency, I have researched these questions in depth. Although some gray areas persist, I believe we have made great strides toward answering these complex questions.

First, what is the scope of the

County Society Roster Changes

BUTLER: Harry M. Davin, MD, President, 532 Main St., Hamilton 45013; Stanley B. Ignatow, MD, Secretary-Treasurer, 630 Eaton Ave., Hamilton 45013-2767.

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WOOD: Jose Guerra, Jr., MD, Secretary-Treasurer, 727 Rosalind Dr., Bowling Green 43402.



physician's responsibility and liability for treatment and treatment decisions? Of course, you are responsible for caregiving in the field under your direction, much as you are in the hospital or your office. "Ohio law does provide certain immunity from liability when you interact with squads. Physicians who assist in

emergency care or treatment by means of communication or telemetering devices are immune from liability for that care or treatment except in cases of willful or wanton misconduct. If you serve a municipality rather than a private service, you are covered by the "sovereign immunity" that protects the municipality from

OHIO MEDI-SCENE

Medical direction liability clarified . . . *continued*

liability. Therefore, your liability as a medical director for emergency care or treatment rendered by emergency squads is minimal. It is, however, present. Anyone can be sued and physicians who have had *one* such case in the past have often incurred sizeable legal fees in their defense. "Physicians directing emergency medical care are not immune from allegations willful or wanton misconduct in their direction of that care." In summary, the immunity provided by Ohio law is of great value to

The malpractice carriers now understand our situation, but approach it differently.

us, but some small degree of liability persists. Therefore, most of us would prefer to be insured against our liability, and after months of discussion with Ohio malpractice carriers, now we all can.

Ohio's four malpractice carriers, the PIE Mutual Company, the Physicians Company of Ohio (PICO), Medical Protective and St. Paul's Fire and Marine Insurance Company were first approached with this question. Each had only a superficial understanding of exactly what the duties and responsibilities of a physician directing emergency medical services entailed. They now all understand our situation but have chosen different ways to approach

it. First and simplest, Medical Protective and St. Paul have decided to cover such activities under their basic malpractice policies. If you have your medical malpractice insurance with Medical Protective or St. Paul, you should write them and have them confirm their coverage for physician direction of emergency medical services. PICO, on the other hand, has chosen to cover our activities only with the purchase of an additional rider to the basic policy, which currently costs \$200 per year. PIE offers protection under its basic policy to any emergency physician who expressly states his responsibility for medical direction.

I am delighted that all Ohio emergency physicians can now continue to play their critical role without fear of personal liability. I hope this discussion has answered your many questions. For further information or details, please contact your malpractice carrier, the Ohio Emergency Medical Services Agency (1-800-233-0785), the Ohio Chapter of the American College of Emergency Physicians (614-846-0076) or the Ohio State Medical Association (614-486-2401). I am indebted to attorney John Adkins, Circleville, to Mrs. Teri Morgan, executive director of Ohio Chapter ACEP and to Mr. Herbert Gillen and Mr. Jerry Campbell, Ohio State Medical Association, for their help in assembling this information and negotiating with the insurance companies.

— *Thomas J. Hall, MD, FACEP*

Post-polio syndrome — an elusive diagnosis

They've already suffered once from the debilitating effects of polio. During the epidemics that swept the U.S. in the late 1940s and early '50s, hundreds of thousands of Americans were crippled or otherwise handicapped by the dread disease; more than 10,000 others died from it.

Now, nearly 40 years later, some polio survivors are experiencing what's known as post-polio syndrome — a renewed sense of fatigue and gradual weakening of the muscles that's frighteningly similar to the original illness.

Since there are an estimated 500,000 polio survivors in the U.S. alone, chances are that most physicians will treat such a patient at some time in their career. The question is, what exactly is post-polio syndrome? Is the polio "coming back," so to speak, or are these patients — now in their 40s, 50s and 60s — simply showing signs of growing old like everyone else?

"(These patients) have an ongoing pain in their muscles, an inability to perform the things they could do before — especially in places where the polio struck," explains Steven Cremer, MD, a rehabilitative medicine specialist and co-director of the polio survivors clinic at the University of Cincinnati Medical Center. "By and large, there's a symptom complex of fatigue and weakness in the same muscles that were originally affected by polio.

"It's a slow, degenerative thing,"

he continues. "You think you're getting a little older, a little more tired."

To illustrate, Dr. Cremer describes the history of a recent (typical) patient of the clinic: A woman, age 55, contracted polio as a teen-ager in the late '40s and suffered paralysis of both legs and her left arm. She was fortunate in that she did not need to be placed on an iron lung to facilitate breathing. After five years of therapy, she was able to walk again with the aid of leg braces and crutches. Years passed without incidence — until now.

"She's got pain and weakness in the legs, trouble breathing, she naps frequently and has an overall feeling of 'I can't get up,'" says Dr. Cremer. "She doesn't want to do anything."

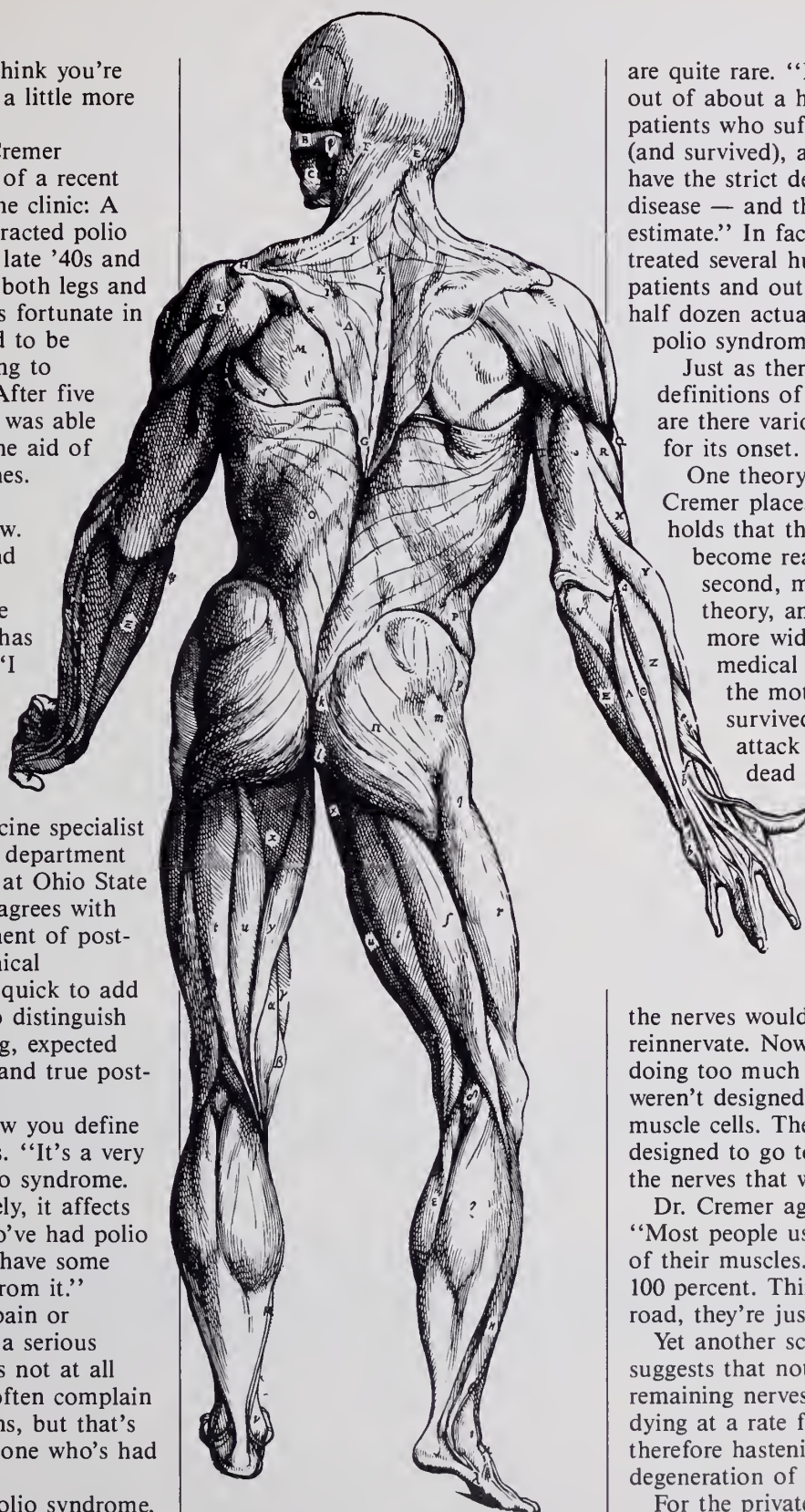
Ernest Johnson, MD, a physical medicine specialist and chairman of the department of physical medicine at Ohio State University, basically agrees with Dr. Cremer's assessment of post-polio syndrome's clinical symptoms, but he is quick to add that it's important to distinguish between normal aging, expected post-polio weakness and true post-polio syndrome.

"It depends on how you define it," Dr. Johnson says. "It's a very loose term, post-polio syndrome. If you define it loosely, it affects all of the people who've had polio in their lifetime and have some (residual) weakness from it."

Having increased pain or weakness years after a serious illness, he explains, is not at all uncommon. "They often complain about aches and pains, but that's apt to occur in someone who's had weakness before."

As for true post-polio syndrome, he continues, "Most of us feel there is no such thing, but if you define it strictly, it means progressive weakness, almost as if (the polio's) been activated again."

Cases such as those, however,



"There's a symptom complex of fatigue and weakness in the same muscles . . ."

are quite rare. "I would guess that out of about a half million patients who suffered from polio (and survived), about 5 percent have the strict definition of the disease — and that's a liberal estimate." In fact, he adds, "I've treated several hundred polio patients and out of those, about a half dozen actually have (post-polio syndrome)."

Just as there are different definitions of the disease, so too are there various explanations for its onset.

One theory, which Dr. Cremer places little stock in, holds that the polio virus has become reactivated. A second, more plausible theory, and one which is more widely accepted in the medical community, is that the motor nerves that survived the virus' initial attack took over for the dead nerves and are now overtaxed.

Dr. Johnson explains: "If (the virus) knocked out 50 percent of the nerves to your muscle, the rest of

the nerves would branch out and reinnervate. Now those nerves are doing too much work. They weren't designed to go to 300 muscle cells. They were, say, designed to go to 150. Those are the nerves that wear out."

Dr. Cremer agrees, adding, "Most people use 20 to 30 percent of their muscles. Polio patients use 100 percent. Thirty years down the road, they're just worn out."

Yet another school of thought suggests that not only are the remaining nerves overtaxed, they're dying at a rate faster than normal, therefore hastening the degeneration of muscle tissue.

For the private practice physician, however, learning how to properly diagnose post-polio syndrome is probably more important than understanding exactly what causes it. And that, according to both Dr. Johnson and



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45	695.00	610.00	1345.00	1165.00	1990.00	1682.50	2615.00	2215.00	
55	1457.50	1377.50	2870.00	2675.00	4277.50	3985.00	5665.00	5295.00	
FEMALE NONSMOKER RATES									
Age	\$250,000		\$500,000		\$750,000		\$1,000,000		
	Std.	Select	Std.	Select	Std.	Select	Std.	Select	
35	\$ 290.00	\$ 235.00	\$ 535.00	\$ 425.00	\$ 775.00	\$ 610.00	\$ 995.00	\$ 795.00	
45	595.00	452.50	1145.00	845.00	1690.00	1232.50	2215.00	1625.00	
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OHIO MEDI-SCENE

Post-polio syndrome . . . *continued*

Dr. Cremer, can be tricky.

"There isn't one test that can tell you whether they have it," Dr. Johnson says. "The single-fiber EMG is the most helpful, but it can't give you the answer. It isn't something you can diagnose at the drop of a hat."

Once again, Dr. Cremer agrees. "It's difficult to sort out, but it's something you follow over time," he says, noting the importance of taking a complete medical history that notes when the patient first began noticing renewed weakness or fatigue, and the severity of their symptoms. "We provide a questionnaire that asks about the problems you had when you were originally sick, whether you had braces and how you're doing now. That helps us organize what we're going to do. It saves time because you know what problems they're having ahead of time. There's more exam time than history taking, and we know ahead of time what kind of specialist should be present at the exam."

But what about the physician with little or no experience in treating post-polio patients? The physician with limited access to high-tech equipment and qualified specialists?

In that case, says Dr. Johnson, the physician should refer the patient to another physician. "(The patient) should go to someone who's more knowledgeable, someone in physical medicine or rehabilitative medicine who knows more about post-polio syndrome."

If a past polio patient is diagnosed as having some degree of post-polio syndrome, there is, unfortunately, nothing that can be done to cure it.

"We can slow it down and we can compensate" for the weakness, says Dr. Cremer, but its progression cannot be stopped.

"We often tell our patients to pace themselves, we teach them how to listen to their own fatigue. With some patients, we have to say 'You just can't work full time anymore. You can only work three days a week,' because if they keep pushing so hard, they'll wear out."

Sheila Stuckey, a past polio patient and a visitor of the clinic, agrees with Dr. Cremer. "I'm in a polio support group and I know a lot of members who have said that they were all told that if they worked hard (to overcome the disease), they'd be able to achieve the things they could do before." It's that push, that drive, she says, that may have hastened many patients' current illness. Now, it's time to slow down, rest and relax. "Sometimes," she says, "it's a matter of changing your whole lifestyle."

If the disease is physically debilitating, it is emotionally devastating as well, and physicians should encourage their patients to seek counseling — either through polio support groups or individual, private counseling.

"Here's someone who conquered a very nasty disease and suddenly they're going downhill again," says Dr. Cremer, explaining why the illness can be so emotionally stressful.

"The support group (in Cincinnati) provides informal counseling," Dr. Cremer continues. "Our program includes a psychological profile, and if we think it's a big problem, they get referred to a therapist."

To the outside world, the thought of having to live with an

incurable, degenerative illness such as post-polio syndrome would be unbearable. But many patients — such as Sheila Stuckey — are amazingly resilient and optimistic.

"I think we'd like to be known as polio survivors," she says, "not polio victims, because look where we're at, look how far we've come." — *Michelle J. Carlson*

Fulton Memorial Lecture Features Cleveland Clinic Chief

William S. Kiser, MD, Chairman of the Board of Governors and Chief Executive Officer of the Cleveland Clinic Foundation will highlight the eighth annual Richard L. Fulton, MD Memorial Seminar, sponsored by Riverside Methodist Hospitals. The seminar will be held October 18, 7:30-9:30 a.m. in Riverside's Susan H. Edwards Auditorium.

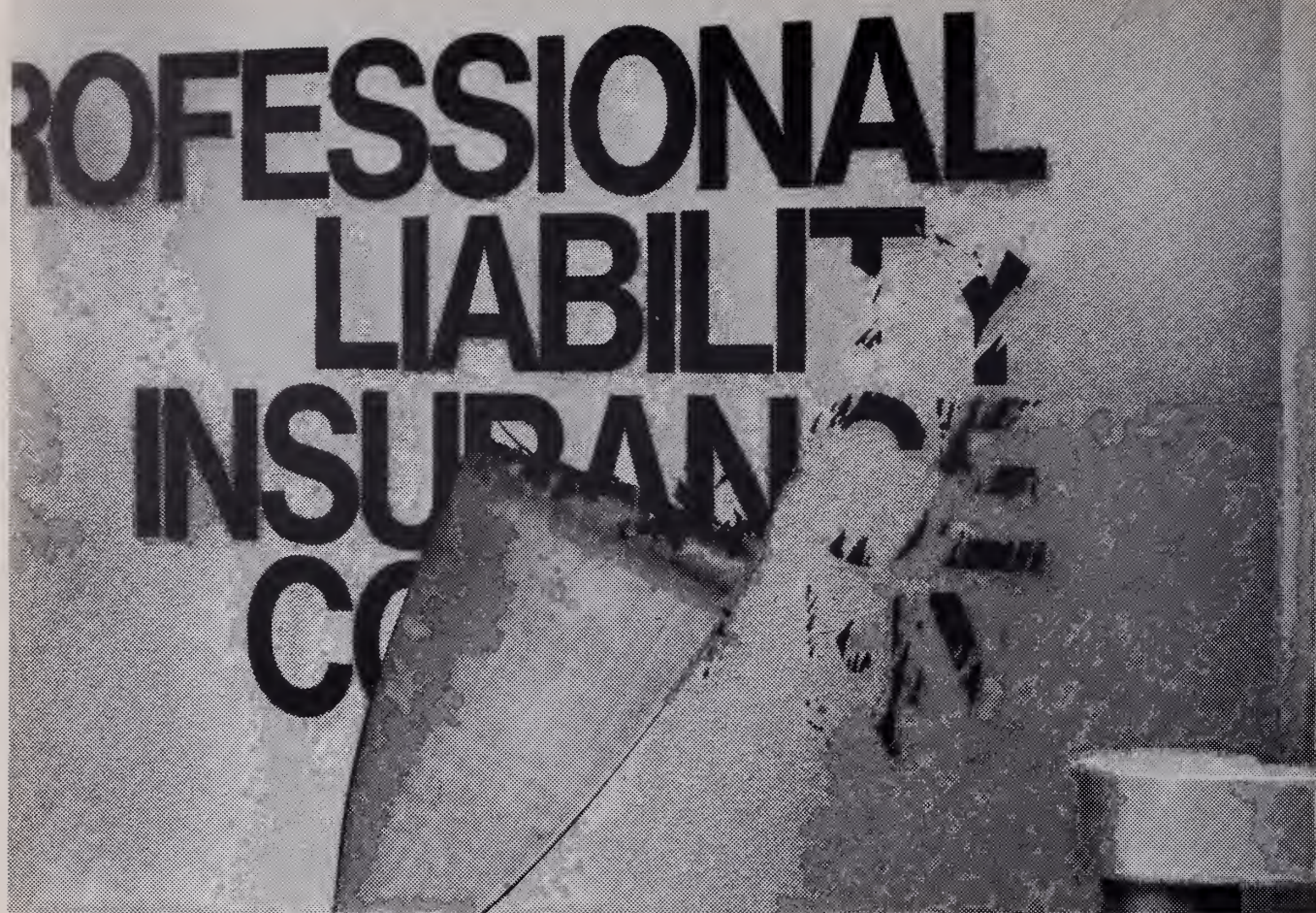
Dr. Kiser will discuss "The Physician and His Changing Relationship with the Hospital," and "The Changing Medical Practice Scene: Is Solo Practice Gone?"

Riverside Methodist Hospitals certifies that the seminar meets the criteria for two hours of Category I CME credit. The seminar is open to the public.

The Richard L. Fulton, MD Memorial Seminar is held annually at Riverside in honor of Richard Fulton, MD, a past president of the Ohio State Medical Association and Academy of Medicine of Columbus and Franklin County.

For more information, call Teresa Altman at Riverside, (614) 261-5468.

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Report of the Annual Business Meeting of the American Medical Association June 26-30, 1988

*By Theodore J. Castele, MD
Chairman, Ohio Delegation to the AMA
and
Donavin A. Baumgartner, Jr., MD
President, Ohio State Medical Association and
Co-Chairman, Ohio Delegation to the AMA*

This report covers some of the important issues voted on by the Ohio Delegation at the 1988 Annual Business Meeting of the American Medical Association in Chicago, Illinois, June 26-30, 1988.

There were 101 reports and 214 resolutions considered by the House of Delegates. The following summary contains 12 resolutions submitted by the Ohio Delegation to the AMA, as well as a report on several other resolutions of importance to Ohio physicians.

OHIO RESOLUTIONS

Organ Harvesting From Nonviable Fetuses

The American Medical Association House of Delegates referred two resolutions, including the following resolution submitted by the Ohio Delegation, to the AMA Board of Trustees for a report at the 1989 AMA Annual Meeting.

“RESOLVED, That the American Medical Association establish ethical guidelines which

address the use of prenatal diagnoses results and organ harvesting.”

Concurrent Care*

The Ohio resolution on concurrent care was amended and adopted by the AMA House of Delegates as follows:

“RESOLVED, That the American Medical Association recommend immediate action by the Health Care Financing Administration (HCFA) and Congress to revise the implementation of Medicare’s

present policy on concurrent care; and be it further

RESOLVED, That the judgment of the attending physician not be curtailed by present limitations of covered benefits for hospitalized patients, especially when physician consultants are needed to maintain the highest standard of care; and be it further

RESOLVED, That the AMA communicate with all members of Congress the impact of these Medicare rules in limiting the quality of services and care to the hospitalized Medicare patient; and be it further

RESOLVED, That the AMA work with HCFA to develop a less cumbersome mechanism that would easily identify all physicians who are providing the highest quality of active concurrent care for patients."

**For further information regarding AMA House of Delegates policy on Medicare, please see page 808.*

Infertility Insurance Coverage

The Ohio resolution on infertility insurance coverage was amended and adopted by the AMA House of Delegates as follows:

"RESOLVED, That the American Medical Association encourage third-party payor health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility."

Nursing Shortage*

The AMA House of Delegates referred the following Ohio resolution to the AMA Board of Trustees for further consideration:

"RESOLVED, That the American Medical Association implement the recommendations contained in Report CC of the

Board of Trustees (I-87), Nursing Education and the Supply of Nursing Personnel in the United States, within the framework of current levels of nursing education; and be it further

RESOLVED, That the AMA open dialogue with the American Nurses' Association to discover creative methods to increase enrollment in nursing education programs, to retain bedside nurses, to provide financial incentives, and to provide incentives for 'retired nurses' to return to bedside nursing."

**For further information regarding AMA House of Delegates policy on this issue, please see section on "Registered Care Technologists."*

Parental and Sick Leave Policies in Residency Programs

The AMA House of Delegates adopted the following Ohio resolution:

"RESOLVED, That the American Medical Association express its support for clearly stated parental and sick leave policies in all accredited residency programs in order to facilitate informed decision-making by applicants to those programs; and be it further

RESOLVED, That parental and sick leave policies be added to residency program information available on the computer information network currently under development by the AMA.

Public Education on Hazards of Tanning Parlors

The AMA House of Delegates adopted the following substitute resolution in lieu of two resolutions, including one from Ohio, on the subject of tanning parlors:

"RESOLVED, That the American Medical Association

- 1) use its public education capabilities to warn the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units;
- 2) endorse the findings released by the FDA warning Americans that the use of UVA tanning booths and sunbeds poses potentially significant health risks to users and should be discouraged;
- 3) work with the FDA to ensure that state and local authorities implement legislation, rules and regulations regarding UVA exposure including posted warnings in commercial tanning salons and spas;
- 4) support in conjunction with various concerned national specialty societies an educational campaign to secure appropriate state regulatory and oversight activities for tanning parlor facilities to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers, and that enforcement of current regulations be intensified."

AIDS Policy*

The AMA House of Delegates referred the following Ohio resolution to the AMA Board of Trustees for action:

"RESOLVED, That the American Medical Association recognize that the confirmed positive HIV individual (two HIV tests and Western Blot) has an infectious disease; and be it further

RESOLVED, That the American Medical Association recommend that state and local health departments adopt the following infectious disease control requirements for the AIDS virus:

- 1) Requiring all laboratories and

physicians to report confirmed positive HIV tests (two HIV tests and Western Blot) determined at other than anonymous testing sites to state and local health departments;

- 2) Requiring physicians and state and local health departments to provide professional counseling to all individuals with confirmed HIV tests;
- 3) Requiring state and local health departments to institute contact tracing in order to notify unsuspecting sexual partners that may have been exposed and should be tested and that physicians who report the names of individuals who test positive for HIV be immune from liability; and be it further

RESOLVED, That the AMA recommend that state and local health departments set up more testing sites where people can go for HIV serologies if they fear they have been exposed to the virus; and be it further

RESOLVED, That the AMA recommend HIV testing for immigrants, prisoners and military personnel, and affirm mandatory HIV testing of organ, tissue, blood and semen donors; and be it further

RESOLVED, That the AMA recommend that voluntary testing should be regularly provided for the following types of individuals who give an informed consent: patients at sexually transmitted disease clinics; patients at drug abuse clinics; pregnant women in high-risk areas in the first trimester of pregnancy; individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior seeking family planning services; and

patients who require surgical or other invasive procedures who are from areas with a high incidence of AIDS or who engage in high-risk behaviors; and be it further

RESOLVED, That the AMA recommend, as a matter of medical judgment, that physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant this measure; and be it further

RESOLVED, That the AMA recommend that anonymous testing centers continue to vigorously encourage individuals who test positive to identify their contacts for the purpose of further testing; and be it further

RESOLVED, That the AMA recommend that all health-care providers, emergency medical personnel, undertakers and embalmers be encouraged to treat all bodies as if they have an infectious disease and undertake universal blood and body fluid precautions on all bodies as recommended by the Centers for Disease Control; and be it further

RESOLVED, That the AMA recommend that all information and records containing any information that identifies a person who is seropositive for the AIDS virus to be kept strictly confidential and that confidentiality guidelines be developed to protect the privacy of the HIV infected person, including when the information and records are released to health-care personnel who have a legitimate medical need to have access to the information in order to assist the patient or to protect the health of others; and be it further

RESOLVED, That the AMA recommend that a physician receive a patient's informed consent to order an HIV serology, unless the

test is medically necessary to avoid or minimize an immediate danger to the health or safety of the patient or another individual; and be it further

RESOLVED, That the AMA recommend that, although insurance companies may have the right to order HIV testing prior to issuing health or life insurance, once a patient has obtained insurance, the insurance company should not cancel or refuse to renew that patient's policy based solely on the fact that the policyholder has been diagnosed as having AIDS, an AIDS-related condition or a confirmed positive HIV test; and be it further

RESOLVED, That the AMA support a national, state and local catastrophic health insurance program to cover the individuals who are confirmed HIV positive and who are uninsurable; and be it further

RESOLVED, That the AMA recommend that more programs be developed to educate the public on the AIDS epidemic; and be it further

RESOLVED, That the AMA support legislation to protect confirmed HIV positive individuals from discrimination in housing, public facilities, educational facilities and public transportation; and be it further

RESOLVED, That the AMA support the position that a person not be discriminated against in his place of employment solely on the basis of a positive HIV test; and be it further

RESOLVED, That the AMA advocate sufficient national funding for AIDS programs and AIDS public education."

It should be noted that most of the Resolveds in this resolution are already AMA policy. However,

there are several Resolveds that differ from AMA policy, such as required physician counseling and catastrophic health-care insurance for HIV positive patients, which will be studied by the Board of Trustees.

**For further information regarding AMA House of Delegates policy on this issue, please see section on "AIDS/Health-Care Workers."*

American Pharmaceutical Association

The AMA House of Delegates adopted the following Ohio resolution:

"RESOLVED, That the American Medical Association continue its surveillance of mail-order prescriptions; and be it further

RESOLVED, That the AMA respectfully request that the American Pharmaceutical Association notify its members that prescriptions be refilled only on the physician's order; and be it further

RESOLVED, That the AMA request that the American Pharmaceutical Association advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled."

Oppose Pharmaceutical Advertising

The AMA House of Delegates adopted the following Ohio resolution:

"RESOLVED, That the American Medical Association publicize its opposition to marketing of prescription drugs to the public.

Membership "Window of Opportunity" Dues Incentive Pilot Program

The AMA House of Delegates

rejected an Ohio resolution that asks that the AMA offer a dues incentive program, similar to the OSMA's "Window of Opportunity" program, which provides reduced dues over a two-year period to new members or former members who have not been members for the previous three years.

The resolution was rejected due to the potentially enormous revenue loss of \$2.4 million that could result if this program were to be implemented on a national level. OSMA's experience with the program will be evaluated and, if warranted, the proposal could be reconsidered by the AMA House of Delegates at a later time.

Employees Right to Choice of Health Insurance Options

The AMA House of Delegates adopted the following substitute resolution in lieu of two resolutions, including one from Ohio, on the subject of employees' choice of health insurance options:

"RESOLVED, That the American Medical Association sponsor or support legislation which would require employers currently required to offer participation in health maintenance organizations (HMOs) to provide employees with a choice of health insurance coverage types, whereby employees have free choice of physicians and health-care facilities.

Standardized Definition of Emergency

The AMA House of Delegates referred four resolutions dealing with emergency services, including one from the Ohio Delegation, to the AMA Board of Trustees. The Ohio resolution asks the AMA to work with other groups, such as the American College of Emergency Physicians, to develop a

standard definition of a "bona fide emergency" to be utilized as a nationally recognized standard for physicians, third-party payors and patients. The other resolutions call for the AMA to:

- Amend section 9121 of COBRA regarding care of patients presenting to the hospital emergency room and to encourage managed health-care programs, state welfare departments, and other state agencies to implement steps to ensure appropriate patient use of hospital emergency rooms;
- Support changes to Medicare regulations governing ambulance service reimbursement;
- Study the effects and problems of provision of emergency care stemming from prior authorization requirements.

These resolutions raise serious interrelated concerns arising from the combined impact of Medicare program requirements and reimbursement policies of managed care systems on the provision of emergency medical care. Because of the close relationship between these resolutions, the importance of the issues involved, and the essential need for a cohesive AMA policy in this area, the Board will carefully consider the issues involved and engage in the necessary fact-finding and policy formulation activities so as to develop a cohesive and internally consistent policy that will not only be responsive to the issues raised in all four resolutions, but also provide long-term policy guidance in this important area.

RESOLUTIONS ORIGINATING FROM NON-OHIO SOURCES **Medicare Reimbursement —** **MAAC Participating and Non-** **Participating Method**

The AMA House of Delegates adopted the following substitute resolution in lieu of six resolutions on this subject:

"RESOLVED, That the American Medical Association reaffirm its policy to support federal legislation that would rectify Medicare contractual inequities with physicians and patients and re-establish the principle of freedom of contract in the practice of medicine; and be it further

RESOLVED, That the American Medical Association continue to evaluate the selective discriminatory nature of Medicare's maximum allowable actual charge (MAAC) and participating physician programs and to continue to take appropriate action to challenge these provisions as well as laws and regulations forcing assignment for laboratory and diagnostic procedures; and be it further

RESOLVED, That the American Medical Association continue to oppose differential treatment of "participating" and "non-participating" physicians under Medicare, including the "Notification of Charges" statement required by Medicare for non-participating physicians, statements on explanations of benefits, and use of participating physician directories; and be it further

RESOLVED, That the American Medical Association work to allow physicians to treat Medicare patients outside of regulatory constraints that threaten the physician/patient relationship."

In addition, the AMA House of Delegates adopted the following resolution regarding MAAC's:

"RESOLVED, That the American Medical Association

seek repeal of the maximum allowable actual charge (MAAC) provision of the 1986 Omnibus Budget Reconciliation Act."

Medicare Reimbursement

The AMA House of Delegates referred two resolutions on the subject of Medicare reimbursement to the AMA Board of Trustees for a report back to the House of Delegates at the 1988 Interim Meeting. One resolution asks the AMA to reaffirm its existing policy on reimbursement disparity and develop and promote federal legislation and regulations that would ensure that all Medicare patients are reimbursed equal amounts for the same CPT code for all CPT codes for medical services and procedures. The other resolution calls on the AMA to support the concept of a unified national reimbursement schedule for Medicare.

Medicare Denials

The AMA House of Delegates adopted the following substitute resolution in lieu of nine resolutions on this subject:

"RESOLVED, That the American Medical Association continue to seek appropriate legislative relief from the "medically unnecessary" provisions of section 9332(c) of the Omnibus Budget Reconciliation Act of 1986 (OBRA), including the repeal of this provision; and be it further

RESOLVED, That until such time as repeal of this provision is achieved, the American Medical Association continue to press HCFA and the Medicare Part B carriers to make further changes in the implementation of this authority to correct problems being experienced, including:

- 1) Urging HCFA and the carriers to make the denial criteria,

parameters of treatment and medical review policies available to the physician community;

- 2) Obtaining assurances that carrier medical review policies are developed with practicing physician advice;
- 3) Continuing to work to assure that physicians are notified by the carrier prior to a "medically unnecessary" notification being sent to a patient;
- 4) Urging carriers to facilitate the expeditious handling of physician requests for reconsiderations and appeals of "medically unnecessary" denials;
- 5) Working to assure that patient notifications are worded in such a way so as not to put into question the attending physicians' professional judgment or the quality of care received and that the services denied be clearly identified (by more than just procedure code) in such notices, and that they be referred to as "not covered by Medicare" as opposed to "medically unnecessary"; and
- 6) Opposing required wording in the patient waiver form (advance exculpatory notice) that suggests that the physician is about to provide medically unnecessary services to his or her patient; and be it further

RESOLVED, That the AMA continue to gather data and information regarding the nature and extent of problems experienced by physicians arising from the implementation of this authority, with particular attention to any evidence suggesting that non-

assigned patient Medicare claims are subjected to greater scrutiny (and more likely denial) than assigned claims; and be it further

RESOLVED, That should neither legislative nor administrative relief be forthcoming, the AMA then explore potential judicial relief.”

In addition, the AMA House of Delegates adopted the following resolution:

“RESOLVED, That the American Medical Association seek and change Health Care Financing Administration policy on a national level, so that all Part B Medicare denials are reviewed by a physician and surgeon.”

Medicaid — Toward Reforming the Program

The AMA House of Delegates adopted a Board of Trustees report, in lieu of three resolutions, which proposes a program that would revamp Medicaid and states the Association’s goal of providing greater equity in the program through the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors), the creation of basic national standards of uniform minimum adequate benefits, the elimination of the existing categorical requirements, and the creation of adequate payment levels to assure broad access to care.

In addition, the AMA House of Delegates referred the following resolution to the Board of Trustees for action and a report back to the House of Delegates at the 1988 AMA Interim Meeting:

“RESOLVED, That the American Medical Association establish a task force, with high priority for funding and staffing, which would be charged with

addressing the problem of indigent health care; and be it further

RESOLVED, That this task force utilize a broad approach which may include formation of a coalition with other interested organizations, solicitation of grants and voluntary contributions, to pursue solutions to the indigent health-care problem.”

A National Study of Resource-Based Relative Value Scales for Physician Services: Criteria for Evaluation and Recommendations for Implementation

The AMA House of Delegates adopted a Board of Trustees report that describes criteria for the AMA’s evaluation of the resource-based relative value scale for physician services being developed by Harvard with the assistance of the AMA, and recommends that a full evaluation of the study by all affected parties be completed before implementation decisions are made and that a reasonable transition period be included before any adoption of a Medicare fee schedule payment system.

Harvard’s primary goals in initiating the RBRVS project were: 1) to develop an RBRVS for each of the (now 18) specialties included in the study to date; and 2) to develop a national cross-specialty RBRVS for these specialties. Related goals were the involvement in the study of a broad range of medical experts to enhance the technical credibility of the RBRVS and agreement within the medical community, and review of the RBRVS by physician, payor and consumer representatives.

The AMA’s major goal in agreeing to work with Harvard in the national RBRVS study was to develop an RVS that, if implemented in a Medicare physician payment system, would

help improve the predictability, administrative efficiency and rationality of Medicare payments for physician services with minimal disruptions in patient care. Payment schedules based on an RBRVS study that incorporated a substantial role for organized medicine were viewed as being more appropriate and acceptable to patients and physicians than such alternative physician payment approaches as physician DRGs and widespread capitation of Medicare beneficiaries.

The RBRVS study will initially be evaluated, therefore, on how well it has achieved these goals. On completion, the study should produce a cross-specialty RBRVS that reflects substantial input from organized medicine, will provide an appropriate basis for Medicare payment, and is likely to provide for an acceptable and smooth implementation.

Physician Collective Bargaining

The AMA House of Delegates referred a Board of Trustees report regarding physician collective bargaining back to the Board for further consideration. The report responds to an earlier resolution calling for the AMA to develop federal legislation to allow physicians to bargain collectively and petition the National Labor Relations Board to broaden the definition of “employee” so that physicians could be included within the definition. The report details AMA activity before the National Labor Relations Board in a regulatory proceeding in which the Association advocated a definition of the term “employee” to bring more employed physicians within the scope of collective bargaining. The NLRB has yet to issue a final rule in that proceeding. Further, the report

discusses negotiations by non-employed physicians, as well as concerns about AMA lobbying to change the antitrust laws.

In addition, the AMA House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association investigate the means to change existing federal antitrust laws to permit collective negotiations on the part of physicians and their organizations."

Monetary Fines as PRO Sanctions

The AMA House of Delegates adopted a Board of Trustees report, in lieu of an earlier resolution which asks the AMA to seek legislative and regulatory changes that would eliminate monetary fines as a potential PRO sanction or a sanction under any statute that authorizes the Inspector General of the Department of Health and Human Services to levy penalties against physicians based on the quality of medical care provided.

The report states that AMA policy traditionally supports the use of physician education and other non-punitive measures to address correctable quality problems. However, in cases where the physician is either unwilling or incapable of meeting community standards of medical practice, it may be necessary to take more stringent measures. In such cases the use of intermediate steps short of an exclusion from the Medicare program may be appropriate. Because of the severe adverse consequences of an exclusion from the Medicare program on a physician's reputation and standing in the community, the Board believes strongly that exclusion from the program should be a measure utilized in the most severe

cases.

The Board is aware that in some cases the cost of defending against a proposed monetary sanction may be greater than the amount of the proposed sanction. As a result, some physicians may pay the fine, particularly if it is a rather modest amount, rather than defend themselves. The Board is concerned, however, that eliminating monetary sanctions would force many physicians who may now be paying rather modest fines to defend themselves against exclusion actions. This would expose the physician to additional time, financial burdens, and other risks. In addition, the Board is concerned that limiting the HHS Secretary to the option of excluding a physician from Medicare would be too rigid and inflexible. It could result in an exclusion sanction being imposed on a physician who might otherwise be subjected to a civil monetary fine.

The Board also believes that the current PRO law and regulations appropriately limit the amount a physician can be fined to the actual or estimated cost of the medically unnecessary or improper service. This limitation ensures that physicians will not be subjected to unreasonably large fines. As a result, the Board supports continuing to allow PROs the option of imposing the intermediate sanction of a monetary fine. The AMA will continue to monitor closely the implementation of the PRO program, including the sanctions process.

Peer Review

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the

American Medical Association affirm that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body so long as the information that is shared is not a proceeding or a document protected by statute or regulation as confidential peer review information."

Registered Care Technologists

The AMA House of Delegates referred an amended Board of Trustees report to the Board for action. The report proposes that the AMA support a pilot project to determine if a registered care technologist (non-nurse, bedside care technician) will be helpful in the provision of bedside care to patients. The goal of the proposed AMA Registered Care Technologist (RCT) program is to contribute an innovative solution to the shortage of bedside personnel that will be timely, cost effective and efficient. The purpose of the plan is to provide a dependable supply of technically oriented bedside caregivers that will improve access of patients to needed medical care in hospitals. It is also the intention of the proposal to 1) provide support services for nurses at the bedside and a recruitment pool for higher education in the health professions; 2) coordinate the fragmented education of certain hospital-based technicians; and 3) organize and implement accredited hospital-based apprenticeship programs and hospital-based inservice programs to teach technical skills to RCTs.

A meeting between the executive directors of associations concerned with providing safe bedside care in long-term and acute care settings, including the American Hospital Association, the Joint Commission



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on Accreditation of Healthcare Organizations, and the AMA, is planned in the near future for the purpose of coordinating the concerns of non-physician associations regarding the bedside care shortage and to focus their efforts on a possible long-term solution.

According to the action plan, the AMA will:

- 1) Be consulted to identify states where the shortage of bedside personnel is crucial and where there is a willingness to participate in a demonstration project for educating RCTs;
- 2) Complete a grant proposal to further develop and implement the RCT demonstration projects through the selected Federation members;
- 3) Seek the cooperation of non-physician associations to improve and market the proposal;
- 4) Seek cooperation of nursing to assure that the RCT project provides a recruitment base for nursing;
- 5) Continue to support nursing in its efforts to recruit and educate nurses for the bedside as an important aspect of this initiative.

AIDS/Health-Care Workers

The AMA House of Delegates adopted the following substitute

resolution in lieu of four resolutions on this subject:

"RESOLVED, That the American Medical Association study the many and varied issues relating to physicians and medical students who become HIV or Hepatitis B positive, particularly the issue of the availability of disability insurance; and be it further

RESOLVED, That because of the extreme urgency of addressing these issues, a comprehensive report be returned to the House of Delegates at the 1988 AMA Interim Meeting."

There are many excellent reports presented to the House of Delegates at each meeting covering a wide range of subjects that are of interest to physicians. These reports, prepared by the AMA Board of Trustees, councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follows. If you would like a copy of these reports, please contact the OSMA office.

1. Costs of Tobacco Use
2. Organ Procedure System — Interim Report
3. Generic Substitution
4. Child Pornography
5. Impact of Product Liability on the Development of New Technologies

6. AIDS Status Report: Situation Update
7. Physicians Serving on Hospital Governing Boards
8. Euthanasia
9. Financing of Care for AIDS Patients — A Progress Report Based on the San Francisco Experience
10. Reducing Transmission of Human Immunodeficiency Virus (HIV) Among and Through Intravenous Drug Abusers
11. Mammography Screening in Asymptomatic Women 40 Years and Older

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Please send me the following AMA report(s) listed in the Summary of Actions Report of the 1988 AMA Annual Meeting:

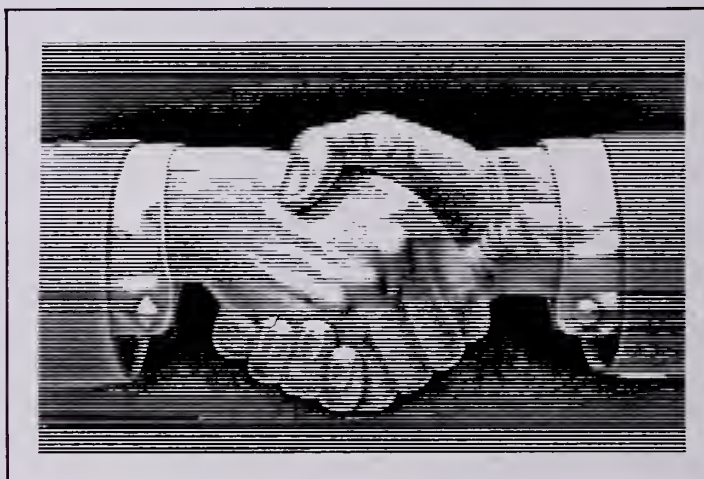
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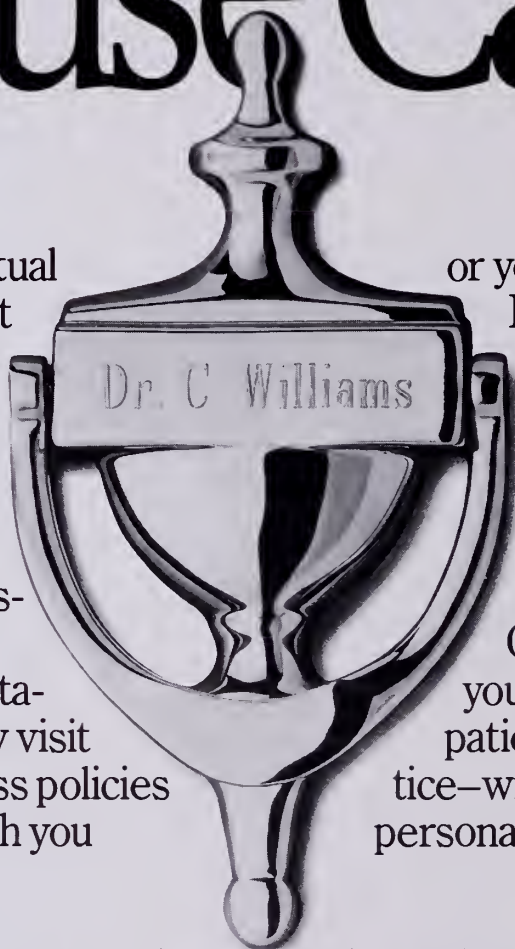
***CLINICAL
UPDATE***

November 11-13, 1988

Cincinnati Convention — Exposition Center

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The Programs . . .

Editor's Note: *The following is a partial listing of programs which were available at press time.*

Advanced Trauma Life Support Course

Date: Thursday, November

10-Friday, November 11

Sponsored by: University of Cincinnati Ohio Committee on Trauma, American College of Surgeons in conjunction with: Ohio State Medical Association 1988 Clinical Update

Course Description:

The patterns of care and outcome of victims suffering severe trauma are greatly influenced by the judgments exercised by the physician on initial contact with the patient. The primary response to patients with major trauma is of critical importance and is facilitated by a well organized plan to assess life-threatening injuries and institute appropriate stabilization and therapy in order to make possible definitive therapy at the appropriate time.

Primary assessment is often futile if measures are not immediately initiated to prevent further deterioration of the clinical status of the trauma patient. The responsibility for appropriate care of critically injured patients rests with the emergency department physician. Appropriate care can

only be accomplished after initial assessment and lifesaving priorities are established.

The ATLS courses combine didactic lectures and practical stations that allow the participant time to perfect his/her skills in the initial assessment, and stabilization phases of trauma patients. The instructor course offers didactic and practical teaching sessions to provide an opportunity for the participant to practice skills in teaching as well.

The ATLS courses have been specifically designed for the primary care physician, emergency department physician and surgeon.

Course Objectives

Upon completion of the ATLS course, the participant will be able to:

- I. Demonstrate concepts and principles of patient assessment.
- II. Establish management priorities in a trauma situation.
- III. Initiate primary and secondary management necessary, within the first hour of emergency care, for

acute life-threatening emergencies.

- IV. Demonstrate the skills necessary in initial management of trauma victims.

- Initial assessment of victims with multiple injuries
- Application of anti-shock garment



- Initiation of intravenous therapy with CVP and shock management
- Adult/infant intubation and nasotracheal intubation
- Radiographic identification of C-Spine injuries
- Cricothyroidotomy
- Pleural decompression and chest tube insertion
- Pericardiocentesis
- Peritoneal lavage
- Venous cutdown
- Extremity and spinal immobilization
- Head trauma management w/ application of cervical traction tongs

Provider Course Schedule

DAY 1

7:30 a.m. to 5:00 p.m.

Lectures:

Course overview & introduction to ATLS
Initial Assessment
Upper Airway Management
Shock
Thoracic Trauma
Abdominal Trauma

Practical:

Animal Lab

1. Cricothyroidotomy
 2. Venous cutdown
 3. Chest trauma management
 - needle decompression
 - tube thoracostomy
 - pericardiocentesis
 4. Peritoneal lavage
- Intubation
Anti-shock garment application
I.V./shock therapy

DAY 2

8:00 a.m. to 5:00 p.m.

Lectures:

Head Trauma
Neck/Spinal Trauma
Extremity Trauma
Burns
Pediatric Trauma/Trauma
Pregnancy
Stabilization and Transport

Practical:

Mr. HURT/Cervical Traction Tongs
Extremity Immobilization
Spinal Immobilization
Initial Assessment-Practice/Test
Scenarios
Written Test

Credits

As organizations accredited for continuing medical education, the American College of Surgeons and the American College of Emergency Physicians designate the Provider Course as meeting the criteria for 16 Category I hours.

General Information

This program is sponsored by the University of Cincinnati. For more information on this or other ATLS courses, contact:
Richard B. Fratianna, MD,
Chairman
Ohio Committee on Trauma
3395 Scranton Road
Cleveland, Ohio 44109
(216) 459-5627

Rita Sauer, RN
University Hospital
231 Bethesda Avenue
Cincinnati, OH 45267
(513) 558-7269

Registration Information

Registration fee for the Provider Course is \$400. **Enrollment for each course is limited to a total of 32 physician participants.**

Registration fees include all course materials, lunch and refreshments.

Courses fill rapidly so early registration is encouraged. Registration fees must be received at least three weeks before the scheduled course in order that participants may receive their manuals in sufficient time to prepare for taking the ATLS course.

Cancellation Policy

Registration cancellations postmarked two weeks before the scheduled course will be assessed a \$50 processing fee which will be deducted from the refund. No refunds will be offered after that time.

ATLS Registration Form

Registration limited to 32 participants; please enroll early.

Registration Fees: Provider Course \$400

Make checks payable to Ohio Committee on Trauma and return this form to:

Richard B. Fratianna, MD, Chairman
Ohio Committee on Trauma
3395 Scranton Road
Cleveland, Ohio 44109

Name _____

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Hospital(s) Affiliation _____

Friday ...

Update on AIDS 1988

Date: Friday, November 11

Time: 9 AM-12:30 PM

This course is an update of the 1987 Plenary Session on AIDS.

Learning Objectives:

The speakers will discuss the following —

1. The AIDS situation in the U.S. with particular emphasis on New York City. The disease will be looked at from a clinician's perspective on treatment and care in New York.
2. Neurologic changes caused by the Human Immunodeficiency Virus (HIV), considering recent research into this subject.
3. The social impact of AIDS including problems associated with AIDS dementia. The physician's approach to the AIDS patient with

neuropsychiatric symptoms will be briefly explored.

After the program, there will be a panel discussion and a question and answer period.

Course Director: Thomas J. Halpin, MD, Chief, Bureau of Preventive Medicine, Ohio Department of Health

Presiding: Albert N. May, MD, Chairman, OSMA Committee on Education

Speakers:

Jeffery C. Hutzler, MD, Director, Outpatient Program, Department of Psychiatry, Cleveland Clinic

Kerry H. Levin, MD, Department of Neurology, Cleveland Clinic

Gary P. Wormser, MD, Professor of Medicine, New York Medical College

News Media Training Seminar

Date: Friday, November 11

Time: 2-5:30 PM

This three-hour seminar covers the rules of the game for conducting a successful news media interview. It includes information on how to prepare for difficult interviews and how to present medical news in an understandable manner. Special attention is given to television news interviews, but the course also covers talk shows and radio and newspaper interviews.

During the course each participant is videotaped doing a mock interview and this tape is critiqued by the instructor. Course enrollment is limited to 15 participants.

Course Instructors: Carol Wright Mullinax, Director, Department of Communications and Physician Marketing, OSMA; Doug Evans, Associate Director, Department of Communications and Physician Marketing, OSMA



Friday ...

Newer Techniques in Management of Headache

Date: Friday, November 11

Time: 4-5:30 PM

Course Description: This course will review some of the newer findings in the pathophysiology of headaches, especially those of the migraine type. The main emphasis, however, will be on the management of the common headache syndromes by both pharmacologic and non-pharmacologic methods. There will be discussion of some of the newer medications and new uses of older medication in preventing and aborting migraine attacks.

Learning Objectives:

1. To update the physician on the latest knowledge regarding pathophysiology of vascular headache.
2. Review the diagnosis of major categories of headache.
3. Enhance the physician's knowledge of aggravating factors in migraine.
4. Enhance the physician's knowledge of medications useful in treating headache.

Speaker:

Robert S. Kunkel, MD, Head, Section of Headache, Cleveland Clinic Foundation, Cleveland

Newer Techniques in the Management of Chronic Pain

Date: Friday, November 11

Time: 2 PM-3:30 PM

The multidisciplinary approach to chronic pain, psychological problems and treatment and treatment of cancer pain will be discussed.

Course Director: Richard V. Gregg, MD, Director of Pain Control Center, University of

Cincinnati Medical Center

Speakers:

Jeffrey Katz, MD; Catherine Rand, MD; Joseph Thomas, MD, all from the Department of Anesthesiology, University of Cincinnati Medical Center

M. Eileen Buban, PsyD, Department of Anesthesia Pain Control Clinic, University of Cincinnati

Acute Rheumatic Fever Update

Date: Friday, November 11

Time: 2 to 3:30 PM

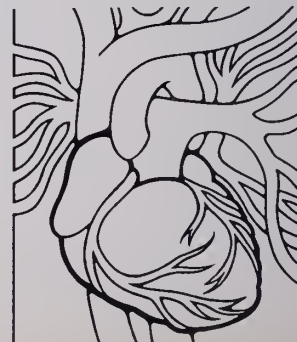
There has been a recent increase in the reported incidence of acute rheumatic fever in the last two years in Ohio. This talk will discuss the recent surge in cases, present the diagnostic criteria for acute rheumatic fever and discuss long-term management.

As a result of this talk the practitioner will have an increased ability to diagnose acute rheumatic fever, and will have improved skills in long-term management.

Course Director: Ellen Buerk, MD, Oxford

Speaker:

David Schwartz, MD, Cincinnati



Chemical Dependence: Help . . .

Hope . . . Healing

Date: Friday, November 11

Time: 2 PM-5:30 PM

This course is sponsored by the OSMA Committee on Impaired Physicians and its action arm the Physician Effectiveness Program (PEP).

This will be an educational program, emphasizing the family aspects of impairment.

Course Director: A.T. "Ted" Puskar, MD, Barberton, Chairman, Subcommittee on Program Planning, OSMA Committee on Impaired Physicians
Speakers:

Daphne K. Defreest, MD, Akron
Thomas L. Haynes, MD, Director of Medical Services, Glenbeigh of Kent Community Hospital, Grand Rapids, Michigan (former member, OSMA Committee on Impaired Physicians)

John E. Koehler, MD, Dayton,



Member, OSMA Committee on Impaired Physicians

William Powell, MD, Millersburg, member, OSMA Committee on Impaired Physicians and Mrs. Powell

Craig T. Pratt, MD, Newark, Addictionologist; Program Director, Shepherd Hill Hospital, Newark, and member, OSMA Committee on Impaired Physicians
Dr. Puskar

Urinary Tract Infections

Date: Friday, November 11

Time: 4 to 5:30 PM

"What's New in Urinary Tract Infections" — Urinary tract infections are a common problem that require management by the primary care practitioner. This talk will discuss the incidence of urethritis, cystitis, pyelonephritis in both children and adults. It will discuss ways to collect specimens, and how to localize urinary tract infections.

Tests of renal function will be discussed.

Practical points to be discussed include sexual activity and UTI, dysuria and reflux.

As a result of this talk the practitioner will be able to increase his diagnostic skills, and be able to use newer modalities of following

chronic conditions.

"Complicated Urinary Tract Infections" — This talk will discuss the more complicated urinary tract infection that is related to structural abnormalities of the genital urinary tract. As a result of this talk the practitioner will be able to know when referral to an urologist is indicated and what evaluation and treatment his patient might be expected to receive.

Course Director: Ellen Buerk, MD, Oxford

Speakers:

Paul Thomas McEnery, MD, Children's Hospital, Cincinnati
Jeffery Wacksman, MD, FAAP, Division of Urology, Children's Hospital Medical Center, Cincinnati

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Saturday . . .

The Use of CT and MRI Scans in Musculoskeletal Problems

Date: Saturday, November 12

Time: 2 PM-4 PM

This course will discuss how MRI differs in each clinical application with CT scan.

Course Director: Randall L. Braddom, MD, Cincinnati

Speakers:

Robert Lukin, MD, Professor, Department of Radiology, University of Cincinnati College of Medicine

Jonathan Moulton, MD, Assistant Professor, Director of Section of Body CT & MRI, Department of Radiology, University of Cincinnati College of Medicine



Diagnosis of Infectious Disease by Direct Microscopy

Date: Saturday, November 12

Time: 9 AM to 12 Noon

This course sponsored by the Ohio Society of Pathologists.

Objectives:

1. Describe and illustrate the application of direct examination of tissue and cellular specimens for identification of specific etiologic agents.
2. Review the application of routine and relevant ancillary staining methods to identify

specific pathogens.

Learner Objectives:

1. Attendee will review the morphologic features of common and uncommon pathogens represented in slides directly prepared from tissue and cellular specimens.

Speakers:

Leona Ayers, MD, The Ohio State University, Dept. of Pathology

Joel G. Lucas, MD, The Ohio State University, Dept. of Pathology

Recognition and Management of Common Dermatological Problems

Date: Saturday, November 12

Time: 9-10:30 AM

The objective of this ninety-minute session is to update the clinical eye of the generalist in making diagnoses and directing therapy of common cutaneous inflammatory and neoplastic disorders. Emphasis will be placed on cutaneous signs of underlying systemic processes. The second

portion of the discussion will be devoted to outlining various dermatologic syndromes of the 1980's which the generalist might encounter in an everyday office setting. Such entities as the dysplastic nevus syndrome and cutaneous manifestations of the AIDS patient will be discussed. Audience participation is encouraged.

Speaker:

Thomas G. Olsen, MD, Dayton

Rheumatology Program
Date: Saturday, November 12
Time: 9 AM-12:30 PM

Medical/Nursing Staff Relationships

Date: Saturday, November 12
Time: 9-10:30 AM

This course is sponsored by the Patient Care Committee of the Ohio Hospital Association and features a panel presentation utilizing three or four hospitals to relate their successful collaboration efforts between physicians and nursing staff.

Course Director: Lucille E. Cotner, RN, Director, Patient Care, Utilization & Peer Review Services, Ohio Hospital Association

Speakers:

Gene A. Butcher, MD, Vice President of Medical Affairs, Western Reserve Care System, Inc., Youngstown

Ruth Eldridge, RN, Corporate Director of Nursing, Western Reserve Care System, Inc., Youngstown

Noma Fidago, RN, Maternity Director, Mary Rutan Hospital, Bellefontaine

Randy L. Longenecker, MD,



Chairman, Department of Obstetrics, Mary Rutan Hospital, Bellefontaine

Judy Womack, RN, Vice President-Operations, Good Samaritan Hospital & Health Center, Dayton

Paul Zych, MD, Emergency Services Physician, Good Samaritan Hospital & Health Center, Dayton

Applications of Special Modern Radiology in Clinical Medicine

Date: Saturday, November 12
Time: 11 AM to 12:30 PM

Speakers:

W.S. Ball, Jr., MD, Cincinnati

Javier Beltran, MD, Columbus

Richard M. Klein, MD, Dayton

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Saturday ...

Physicians As Parents: The Impact on Children and Spouses

Date: Saturday, November 12

Time: 11 AM to 12:30 PM

This course sponsored by the Ohio Psychiatric Association.

Presenter: Michael J. Maloney, MD, Director of Child & Adolescent Psychiatry, Associate Professor of Psychiatry & Pediatrics, Children's Hospital Medical Center, University of Cincinnati College of Medicine



Childhood Onset Obesity

Date: Saturday, November 12

Time: 11 AM-12:30 PM

Learning Objectives:

Following presentation and discussion on childhood onset obesity the physician will have the information necessary to:

- 1) Explain the need for health professionals to be concerned about the increasing prevalence of obesity in the childhood age groups.
- 2) Will be able to list the immediate complications that are caused by childhood obesity.
- 3) Will be able to list the long-term complications that have been associated with long-

standing obesity from childhood.

- 4) Will be able to list the differential diagnosis of obese conditions in childhood.
- 5) Will have an organized approach to the evaluation of a child with significant obesity.
- 6) Will be able to outline a treatment program for the family to implement for the obese child.

Speaker:

William B. Zipf, MD, Associate Professor, Pediatric Endocrinology/Children's Hospital and The Ohio State University, College of Medicine

Pulmonary Pathology

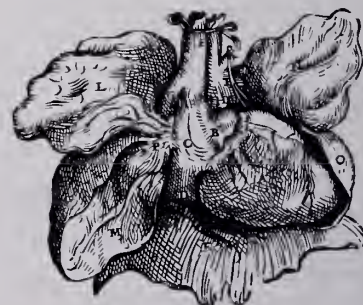
Date: Saturday, November 12

Time: 1 to 4 PM

This course sponsored by the Ohio Society of Pathologists.

Speaker:

Sanuel Yousem, MD, University of Pittsburgh



Practical Preventive Medicine for the Primary Care Physician

Date: Saturday, November 12

Time: 2 to 5:30 PM

"Stroke" — The lecture will focus on identifying the risk factors for ischemic stroke (cerebral infarction) such that diagnostic and therapeutic plans can be generated for individual patients.

"Hyperlipidemia and Heart

Disease"

Speakers:

"Stroke" — Cathy A. Sila, MD, Cleveland Clinic Foundation

"Hyperlipidemia and Heart Disease" — Manuel Tzagournis, MD, Dean, College of Medicine, The Ohio State University

Rosemary Riley, PhD, Cardiac Rehabilitation Program on Diet and Nutrition, The Ohio State University

The Treatment of Life-Threatening Acute Pancreatitis

Date: Saturday, November 12

Time: 2 to 3:30 PM

Objectives: To present the manifestations of massive acute pancreatitis, the treatment of the disease and the results including mortality rates to be anticipated.

Learning Objectives: Should include the ability to recognize the life-threatening form of the disease in order to manage such patients in an intensive care setting. The physician should be able to

understand the basis for supportive therapy including the facets of blood volume, respiratory, renal and nutritional support and be able to recognize the onset of secondary infection. He should be able to gain insight into the possible indications for delayed laparotomy and the short- and long-term results to be anticipated.

Speaker:

John M. Howard, MD, Professor of Surgery, Medical College of Ohio, Toledo

Tax Strategies After Tax Reform

Date: Saturday, November 12

The following is a partial list of the benefits you can expect to receive by attending this seminar:

- 1) How to pick your best business form — corporate or proprietorship;
- 2) 4 strategies to maximize your business automobile deductions and audit-proof your records;
- 3) How to finance your child's college education without spending a dime of your own money;
- 4) When it's appropriate to hire your child or spouse in your business;
- 5) 27 new strategies to get the

maximum travel and entertainment deductions;

- 6) How to select the proper depreciation method for both regular and alternative tax purposes;
- 7) How to put over \$10,000 in your pocket with one of seven strategies for claiming the home-office deduction;
- 8) 21 changes you must make in your business strategies before the end of 1988;
- 9) 17 strategies you should follow to reduce your chances of IRS audit.

This program is provided by the Tax Reduction Institute of Washington, D.C.

Seminar on Diffuse and Inflammatory Lung Disease

Date: Saturday, November 12

Time: 1 to 4 PM

This course sponsored by the Ohio Society of Pathologists.

Objectives:

1. Describe and illustrate via case discussion format new concepts in the following types of diffuse lung disease:
 - a. bronchiolar disease
 - b. immunologic-based lung disease
 - c. drug-induced pneumonitis
 - d. lung transplantation
 - e. infection in the immunocompromised host

Learner Objectives:

1. Attendee will become familiar with newly described diffuse lung diseases.
2. Based on this newly acquired information the attendee will be able to formulate and resolve a more complete and relevant differential diagnosis in the described conditions.

Speaker:

Samual Yousem, MD, Assistant Professor, Department of Pathology, Presbyterian-University Hospital of Pittsburgh

**OSMA Clinical Update
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Sunday ...

10 Most Common Reasons Doctors Get Sued

Date: Sunday, November 13

Time: 9 to 10 AM (10 to 10:30 —
Q & A Session)

This program is a slide/lecture presentation dealing with the causes of loss in medical liability cases, and some techniques to help reduce or eliminate the possibility of being sued.

After the program there will be ample time for questions.

Course Presenter: Ronald L. Gladman, Vice President/Risk Management, Physicians Insurance Company of Ohio, Pickerington



Office Management of Asthma

Date: Sunday, November 13

Time: 9 AM-10:30 AM

Asthma ranks among the most common chronic diseases treated by primary care practitioners. Decision analysis about treatment priorities depends upon fundamental knowledge about the pathophysiologic nature of asthma. Although smooth muscle constriction is one of the most important components of asthma and must be treated promptly, modern research now indicates that the chronic inflammatory aspects of asthma may have equal significance in the overall management of the disease.

The success of asthma management is based upon a stepwise approach to treatment modalities both in the office and in the emergency room. The course will describe how to classify severity stages of asthma and how to formulate rational treatment decisions at each level of severity.

Special emphasis will be given to the proper use of beta₂ agonists and theophylline. A major part of the course will be concerned with proper approach to the preventive aspects of asthma including drugs that affect the chronic inflammatory pathophysiologic process. The importance of cromolyn sodium and glucocorticosteroids will be emphasized. Several new approaches to corticosteroid-sparing drugs will also be discussed.

Speakers:

I. Leonard Bernstein, MD, Clinical Professor of Medicine and Environmental Health Sciences, Co-Director of the Allergy Research Laboratory and the Allergy Training Program, University of Cincinnati College of Medicine

David I. Bernstein, MD, Assistant Professor of Medicine, University of Cincinnati College of Medicine

Impotence & Frigidity**Date: Sunday, November 13****Time: 9-10:30 AM****Speakers:**

Kailash R. Kedia, MD, Lutheran
Medical Center, Cleveland
Sherelynn Lehman, Cleveland

**Office Ophthalmology for the
Primary Care Physician****Date: Sunday, November 13****Time: 9-10:30 AM**

Course Objectives: The course participant will be able to assess and manage minor eye trauma, ocular foreign bodies and the red eye. He/she will be able to screen for common eye problems like cataracts, glaucoma and strabismus. The objectives also

serve as a course description.

Course Director: Joel G. Sacks, MD, Professor and Chairman, Department of Ophthalmology, University of Cincinnati Medical Center

Speaker:

Joshua J. Sands, MD, Assistant Professor of Clinical Ophthalmology, University of Cincinnati Medical Center

Infectious Disease/Antibiotics**Date: Sunday, November 13****Time: 9-10:30 AM**

Course Description: This session will elucidate the recent advances in parenteral and oral therapy of infections outside the hospital. Patient selection, technical aspects, appropriate drugs and medicolegal considerations will be discussed. New drugs and administration equipment will be highlighted by the speakers.

Educational Objectives:

1. Enable the physician to identify patients appropriate for home antibiotic treatment.
2. Provide physician with information necessary to select

the best antibiotic for home treatment and subsequent monitoring.

3. Give physician basic data on new intravenous pumps for home use.
4. Make physician aware of the economic and legal aspects of outpatient antibiotic therapy.

Course Director & Speaker:

H. Bradford Hawley, MD, FACP, FCCP, Professor of Medicine, Chief of Infectious Diseases, Wright State University School of Medicine
Philip Hanus, PharmD, Clinical Coordinator, Department of Pharmacy, Good Samaritan Hospital & Health Center

OSMA Clinical Update
November 11-13, 1988
Cincinnati Convention
Center

OSMA CLINICAL UPDATE

Ohio State Medical Association "CLINICAL UPDATE: 1988"

FRIDAY, NOVEMBER 11

- Update on AIDS: 1988 (3 hrs.) (9:00 AM to 12:30 PM including break)
- Newer Techniques in Management of Chronic Pain (1½ hrs.) (2:00 PM to 3:30 PM)
- Newer Techniques in Management of Headache (1½ hrs.) (4:00 PM to 5:30 PM)

- Acute Rheumatic Fever Update (1½ hrs.) (2:00 PM to 3:30 PM)
- Chemical Dependence: Help, Hope, Healing (3 hrs.) (2:00 PM to 5:30 PM) (No charge — please register)
- Managed Care, A Medical Perspective (2:00 PM to 5:30 PM)
- Media Training Seminar (3 hrs.) (2:00 PM to 5:30 PM)

(No charge — must pre-register — max. reg. 15)

- Urinary Tract Infections (1½ hrs.) (4:00 PM to 5:30 PM)

SATURDAY, NOVEMBER 12

- Medical/Nursing Staff Relationships (1½ hrs.) (9:00 AM to 10:30 AM) (No charge — please register)
- Recognition & Management of Common Dermatological Problems for the Primary Care Physician (1½ hrs.) (9:00 AM to 10:30 AM)
- Rheumatology Program (3 hrs.) (9:00 AM to 12:30 PM) (No charge to Ohio Rheumatism Society members — please register)
- Pathology Program (6 hrs.) (9:00 AM to 4:00 PM) (No charge to Ohio Society of Pathology members — please register)
- Applications of Special Modern Radiology in Clinical Medicine (1½ hrs.) (11:00 AM to 12:30 PM)
- Management of Obesity in Children (1½ hrs.) (11:00 AM to 12:30 PM)
- Physicians as Parents: The Impact on Children and Spouses (1½ hrs.) (11:00 AM to 12:30 PM) (No charge to Ohio Psychiatric Association members — please register)
- The Treatment of Life-Threatening Acute Pancreatitis (1½ hrs.) (2:00 PM to 3:30 PM)
- Practical Preventive Medicine for the Primary Care Physician (3 hrs.) (Stroke) & (Risk Factors of Ischemic Heart Disease) (2:00 PM to 5:30 PM)
- The Use of CT and MRI Scans in Musculoskeletal Problems (2 hrs.) (2:00 PM to 4:00 PM) (No charge to Ohio Society of Physical Medicine & Rehabilitation members — please register)

SUNDAY, NOVEMBER 13

- The Most Common Reasons Doctors Get Sued (1½ hrs.) (9:00 AM to 10:30 AM) (No charge — please register)
- Office Management of Asthma (1½ hrs.) (9:00 AM to 10:30 AM)
- Infectious Diseases/Antibiotics (1½ hrs.) (9:00 AM to 10:30 AM)
- Office Ophthalmology for the Primary Care Physician (1½ hrs.) (9:00 AM to 10:30 AM)
- Impotence and Frigidity (1½ hrs.) (9:00 AM to 10:30 AM)

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"CLINICAL UPDATE: 1988"

Cincinnati Convention Center/Clarion Hotel

November 11-13, 1988

Course Registration Form

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TUITION SCHEDULE FOR COURSES

Please indicate membership status:

- | | |
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| ☐ OSMA Member | \$10 per credit hour |
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| ☐ Medical Student Member | \$ 3 per credit hour |

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No. of Luncheons: _____ Friday _____
_____ Saturday _____
No. of extra luncheon tickets: _____ x \$8 = \$ _____

Please indicate total number of credit hours:

_____	x	\$10 (Members)	= \$	_____
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"Tax Strategies After Tax Reform" seminar has been selected by OSMA — Please enroll me in the "Tax Strategies After Tax Reform" seminar to be held on *Saturday, November 12* at the Cincinnati Convention Center during the OSMA Clinical Update.

Registration:	8:30 AM
Course Begins:	9:00 AM
Lunch:	12:30 PM
Course Resumes:	2:00 PM
Adjournment:	4:00 PM

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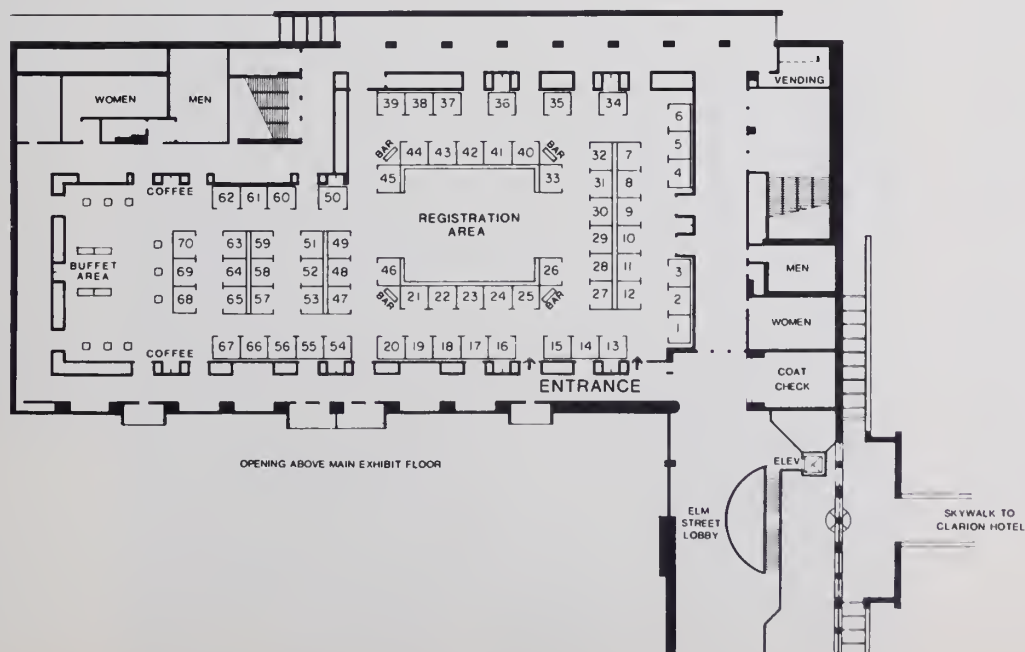
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A "Window of Opportunity" for Nonmembers

By Katherine E. Wisse

Donavin A. Baumgartner, Jr., MD, OSMA President, in his inaugural address chose a new definition for the term UCR — Unity, Communication and Responsibility.

He stated that, "Responsibility includes the commitment to the profession we have chosen — the return of what has been given to us by those in the past. This includes membership. We can no longer sit and wait for our colleagues to join us. We must recruit. A strong voice depends on numbers and we must assure that our numbers increase and remain strong."

The OSMA Membership Committee is trying to make it easier for nonmembers to join by creating a one-time "window of opportunity" dues reduction. This dues reduction begins now and will continue through 1989.

Who qualifies for the reduction?

- Physicians who have never been members.
- Former members who have not been a member for the previous three years.

What is the OSMA dues rate for those who qualify?

- A physician joining in the first quarter, pays 50% (\$197.50)
- A physician joining in the second quarter, pays 37.5% (\$148)

- A physician joining in the third quarter, pays 25% (\$98.75)

- A physician joining in the fourth quarter, pays 12.5% (\$49.38)

50% for the subsequent year (\$197.50)

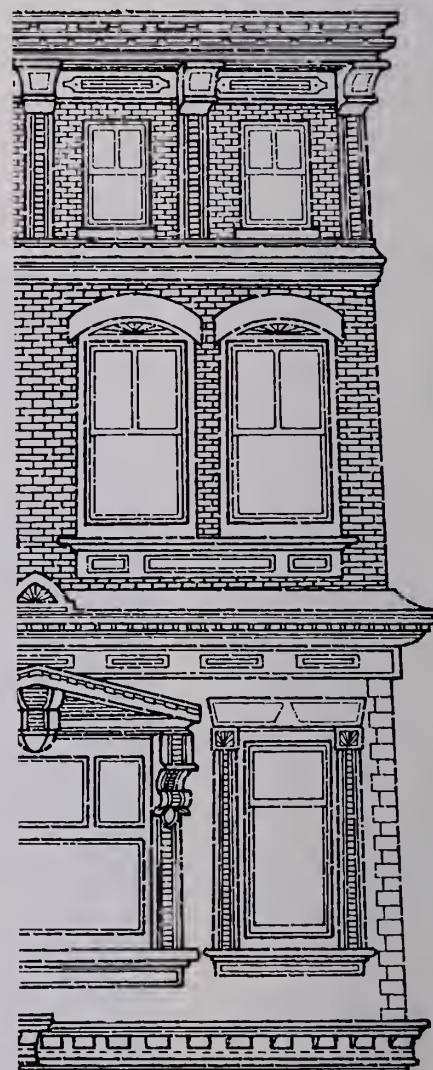
100% for following years (\$395)

Membership in the physician's local medical society is necessary to be eligible for OSMA membership.

The OSMA Membership Committee is actively working toward a greater OSMA membership base. Its dedication is evidenced by its August meeting, the last committee meeting at 600 S. High Street, held on moving day.

Thomas R. Leech, MD, Chairman of the Membership Committee, is confident that this window of opportunity will encourage more nonmembers to join.

If any of your colleagues do not belong, you can meet your commitment to the profession you have chosen by informing them of this special opportunity. You will also benefit by earning credit toward your membership Outreach award. Even more important, however, is that OSMA will have an even stronger voice on behalf of the physicians in Ohio.



Katherine E. Wisse is the Director of OSMA's Department of Membership Development.

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Attention OSMA Members

December 31, 1988 is the deadline — that is when your membership in your county society and the Ohio State Medical Association and the American Medical Association will expire if you haven't paid your 1989 dues.

Your membership in the county medical society, the OSMA and the AMA shows your support for organized medicine and increases its influence on the practice of medicine.

As a member, you are entitled to take advantage of the many benefits offered by the OSMA that are listed on this page.

If you are retired or disabled and are eligible for exemption from OSMA dues payment, notify your society executive director or secretary/treasurer. This exemption will continue annually unless you reenter practice.

For nonresidents, or those planning to leave Ohio, keep in touch with your colleagues and the activities of the OSMA for just \$40 a year.

For further information about your medical association membership, please contact Katherine Wisse, OSMA Director of Membership Development, at (614) 486-2401.

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INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both additional medication, parenterally administered, and close monitoring, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e., nausea and restlessness) may occur frequently when initiating therapy, but are usually transient, when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently, *serious toxicity is not reliably preceded by less severe side effects.*

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with ephedrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether the bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets. The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered

1. Every 24 hours in children under 12 years of age, have not been established.
2. Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

1. *Gastrointestinal:* nausea, vomiting, epigastric pain, hematemesis, diarrhea.
2. *Central nervous system:* headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. *Cardiovascular:* palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.
4. *Respiratory:* laryngospasm.
5. *Renal:* albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuretics.
6. *Other:* rash, hyperglycemia and inappropriate ADH syndrome.

OVERDOSAGE Management: If potential oral overdose is established and seizure has not occurred

- A. Induce vomiting.
- B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken).
- C. Administer activated charcoal.
- If patient is having a seizure
 - A. Establish an airway.
 - B. Administer oxygen.
 - C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
 - D. Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Coma:

- A. Maintain airway and oxygenation.
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis; however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert.

Revised 6/87

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OBITUARIES

James M. Andrew, MD, Columbus; State University of New York, Downstate College of Medicine, Brooklyn, NY, 1947; age 66; died July 12, 1988; member OSMa and AMA.

John Bakos, MD, Chico, CA; Ohio State University College of Medicine, 1925; age 89; died May 18, 1988; member OSMa and AMA.

Walter C. Boenheim, MD, Columbus; Albertus Universitaet Medizinische Fakultät, Konigsberg, Germany, 1922; age 91; died August 6, 1988; member OSMa and AMA.

Gabriel P. Escobar, MD, Cleveland; Facultad de Medicina de la Universidad Nacional de Columbia, Bogota, Cundinamarca, Columbia, 1944; age 71; died July 4, 1988; member OSMa and AMA.

John James Evans, MD, Cleveland; Loyola University Stritch School of Medicine, Maywood, IL, 1936; age 80; died June 3, 1988; member OSMa and AMA.

David H. Goodman, MD, Cleveland; Case Western Reserve University School of Medicine, 1931; age 81; died May 25, 1988; member OSMa and AMA.

Douglas Porter Graf, MD, Cincinnati; Harvard Medical School, Boston, MA, 1940; age 71; died June 26, 1988; member OSMa.

Tom D. Halliday, MD, Marietta; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1959; age 54; died July 3, 1988; member OSMa and AMA.

Charles W. Harding, MD, Worthington; Ohio State University College of Medicine, 1942; age 72; died June 24, 1988; member OSMa and AMA.

Raymond Hellmann, Jr., MD, Cincinnati; St. Louis University School of Medicine, 1947; age 64; died June 24, 1988; member OSMa and AMA.

Robert B. Kubek, MD, Cleveland; Duke University School of Medicine, Durham, NC, 1944; age 69; died June 24, 1988; member OSMA and AMA.

Abe Kuhr, MD, Dayton; Ohio State University College of Medicine, 1931; age 82; died July 28, 1988; member OSMA and AMA.

John F. Messina, MD, Woodland Hill, CA; Case Western Reserve University School of Medicine, 1942; age 71; died June 7, 1988; member OSMA and AMA.

John Joseph Michael, MD, Cincinnati; University of Cincinnati College of Medicine, 1962; age 61; died July 26, 1988; member OSMA.

William Mishler, MD, Northfield; St. Louis University School of Medicine, St. Louis, MO, 1932; age 82; died June 6, 1988; member OSMA and AMA.

Robert E. Moffatt, MD, Mansfield; Medical College of Commonwealth University School of Medicine, Richmond, VA, 1943; age 70; died June 3, 1988; member OSMA and AMA.

William G. Myers, MD, Columbus; Ohio State University College of Medicine, 1941; age 79; died June 16, 1988; member OSMA.

Max Nussbaum, MD, Cleveland; Medizinische Fakultät der Julius Maximilians Universität, Würzburg, Bayern, Germany, 1924; age 88; died June 17, 1988; member OSMA and AMA.

Stewart G. Patton, Jr., MD, Youngstown; University of Pittsburgh School of Medicine, Pittsburgh, PA, 1942; age 78; died July 14, 1988; member OSMA and AMA.

James F. Scott, Sr., MD, Portsmouth; Ohio State University College of Medicine, 1929; age 84; died June 21, 1988; member OSMA and AMA.

ARNALDO J. ABREU, MD, Uniontown; Facultad de Medicina de la Universidad de La Habana, La Habana, Cuba, 1949; age 64; died April 17, 1988; member OSMA and AMA.

HAROLD R. BOLMAN, MD, Sandusky; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1928; age 85; died February 4, 1988; member OSMA and AMA.

ALBERT J. FARRELL, MD, Cincinnati; University of Cincinnati College of Medicine, 1944; age 66; died February 8, 1988; member OSMA and AMA.

GEORGE E. GARDNER, MD, Lancaster; Ohio State University College of Medicine, 1934; age 80; died April 15, 1988; member OSMA and AMA.

LEROY W. MATTHEWS, MD, Robbinsdale, MN; Harvard Medical School, Boston, MA, 1949; age 62; died April 5, 1988; member OSMA and AMA.

FRANK MCDONALD, SR., MD, Atlanta, GA; University of Pennsylvania School of Medicine, Philadelphia, PA, 1935; age 78; died April 14, 1988; member OSMA and AMA.

ROBERT E. MERRILL, MD, Riviera Beach, FL; Ohio State University College of Medicine, 1935; age 77; died March 18, 1988; member OSMA and AMA.

JOSEPH G. PEIL, MD, Middletown; Indiana University School of Medicine, Indianapolis, IN, 1948; age 64; died April 25, 1988; member OSMA and AMA.

JOSEPH F. POKORNY, MD, Bayview, ID; Orvosi Fakultás Tudományegyetem, Budapest, Hungary, 1934; age 82; died February 22, 1988; member OSMA and AMA.

AVERY D. POWELL, MD, Tiffin; Ohio State University College of Medicine, 1932; age 86; died January 4, 1988; member OSMA and AMA.

OHIO Medicine Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be DOUBLE SPACED with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) should bear the figure number and author's name on back. When pertinent, the top of the photograph should be indicated. Do not clip or write on the back of the photos with a hard pencil, etc.

(b). The author should have written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

11. **CASE HISTORIES.** The *Journal* does not accept case histories.

12. **EDITORIAL ASSISTANCE.** Michelle Carlson, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Dealing With the Bad Medical Result

In earlier editions of the *Loss Awareness Bulletin*, we have explored some of the key areas of risk exposure including medical records; attention to practice details; practice beyond training or expertise; and the breakdown in doctor-patient communication.

An additional area — and one which occurs less frequently — also needs to be a cause for concern: the bad medical result.

When this occurs, it can become an extremely difficult event to deal with for several reasons.

- First, it is usually unexpected and it is usually unexplainable.
- Second, the bad result is one which in all likelihood will not happen again . . . but *this* time, to *this* patient, it did.
- Third, in the absence of a sound medical explanation of why the bad result occurred, a jury generally will assume that someone clearly and undeniably made a mistake.

There really is no way to avoid this unfortunate situation. But there are a number of steps that can lessen the secondary effects that a bad result produces.

The importance of effective doctor-patient communication has been stressed in other issues of this bulletin. This rapport becomes of even greater significance in the event of a bad result.

Based upon its claims experience data, Physicians Insurance Company of Ohio believes that a

major factor in malpractice loss prevention focuses on the actions of a doctor before and after a bad result. What the doctor does at these times can affect whether a patient will or will not pursue a claim.

One of the frequent allegations in “bad result cases” is the lack of adequate informed consent. Studies show that adequate informed consent makes good medical sense because it better

Adequate informed consent makes good medical sense because it better prepares a patient for any untoward occurrence...

prepares a patient for any untoward occurrence resulting from treatment.

Additionally, informed consent benefits the patient as well as the physician: It can help lessen the frequency of what are classified as unmeritorious or unwarranted claims against a physician — claims which may be based on lack of understanding or upon expectations that are unrealistic.

A physician’s openness to communication and the willingness to offer clear and understandable

information promote increased patient awareness and acceptance.

After a bad result has occurred, it may be more difficult and painful to maintain rapport with a patient and his family — but this may well be the most important time for the physician to be present and to be available to deal with the patient’s medical situation. Such openness can help head off litigation.

Without information and communication, a vacuum often is created. If such a vacuum exists when a physician absents himself after the bad result occurs, the void can likely be filled by others who may try to convince the patient that a bad result can become a good result by filing a malpractice claim.

The bad result does and will occur — most physicians have encountered the situation in their practices — yet the physician has added responsibility in the way he deals with the patient before and after the outcome is known. Adequate informed consent, open communication and availability to both patient and family are basic elements in lessening the chance of a professional liability claim.

The Loss Awareness Bulletin is written by the subcommittee on loss awareness through the OSMA’s Task Force on Professional Liability.

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All transdermal nitroglycerin products are being marketed pending
final evaluation of effectiveness by the FDA. Please consult
brief summary of Prescribing Information on the following page.

C I B A

1988, CIBA 629-5558-A

**BRIEF SUMMARY (FOR FULL PRESCRIBING
INFORMATION, SEE PACKAGE INSERT)**

INDICATIONS AND USAGE

This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS

Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS

In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS

Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS

Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued. Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION

Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response.

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Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS

A patient leaflet is supplied with the systems.

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C87-23 (Rev 7/87)

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C I B A

References:

1. Martines C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium. San Francisco, October 1987.

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Contact: Abraham Heller
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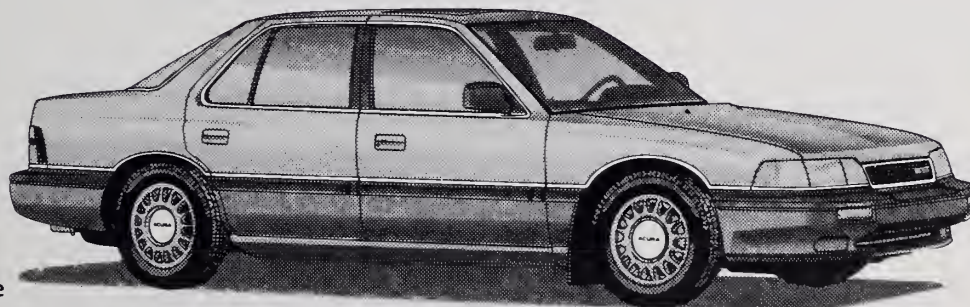
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OHIO, CLEVELAND. Private practice opportunities available within an urgent care setting, with fee-for-service compensation in addition to annual salary of \$75,000-\$80,000. Board-Certified/Eligible-FP/GP/EM/Surg/IM preferred. For more information contact Mitchell Leventhal, MD, at (216) 642-1440, or send CV, in confidence, to 6133 Rockside Road, Suite 10, Independence, OH 44131.

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OHIO (NORTHEAST): Opportunity for staff emergency physician. College-town hospital located near Youngstown, Cleveland, Akron and Pittsburgh, interested in BC/BP emergency physicians. ED patient volume is over 20,000 with high acuity at this 209-bed community hospital. Estimated fee-for-service compensation is \$120,000. Contact: Jim McKenney, Fischer Mangold, Department A, P.O. Box 788, Pleasanton, CA 94566, (415) 484-1200 in California, (800) 227-2092 outside California.

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continued on page 848



“Okay, so I know I need iron. Where do I get it?”

Faced with a Recommended Daily Dietary Allowance of 18 mg, the question is a good one for women aged 19-50. Iron is one of the nutrients most often lacking in the American diet. Low intakes of iron over prolonged time can lead to iron deficiency anemia.

In the 1986 USDA Continuing Survey of Food Intakes by Individuals¹, women of child-bearing years reported a mean intake of 1588 calories a day. Since the American diet averages about 6-7 mg of iron per 1000 calories, it's not surprising that the same survey found that most of these women are getting about 60 percent of their RDA for iron.

Yet consider, one three-ounce serving of lean sirloin contains 2.8 mg of iron, about forty to sixty percent of which is heme iron, the most bioavailable form. In addition, the presence of beef or other meats in a meal increases the bioavailability of nonheme iron from foods such as vegetables and grains.

Importantly, lean beef can also meet fat and cholesterol guidelines of most leading heart and health authorities. The how-to's are good

advice for almost anyone.

Start with “The Skinniest Six” shown below. None is more than 180 calories per three-ounce cooked, trimmed serving. All are easy to specify at the meat counter.

These six cuts also simplify portion control. Four ounces uncooked equals about three ounces cooked. Grilling, broiling and roasting add no extra fat in cooking. And the taste of beef makes it easy to dispense with fat-laden sauces.

Carefully chosen, prepared and served, “The Skinniest Six” provide an impressive list of essential nutrients for under 180 calories per three-ounce serving.

And as part of a specific plan to increase dietary iron, in a balanced diet beef can be one of the best-tasting recommendations you'll ever make.



BEEF



“The Skinniest Six”*

Eye of Round	Round Tip	Top Loin	Top Round	Sirloin	Tenderloin
1.65 mg iron	2.50 mg iron	2.10 mg iron	2.45 mg iron	2.85 mg iron	3.05 mg iron
155 calories	162 calories	172 calories	162 calories	177 calories	174 calories
5.5 g total fat	6.4 g total fat	7.6 g total fat	5.3 g total fat	7.4 g total fat	7.9 g total fat
(2.1 g saturated fat)	(2.3 g saturated fat)	(3.0 g saturated fat)	(1.8 g saturated fat)	(3.0 g saturated fat)	(3.1 g saturated fat)
59 mg cholesterol	69 mg cholesterol	65 mg cholesterol	72 mg cholesterol	76 mg cholesterol	72 mg cholesterol

Uncooked whole cuts are shown for purpose of identification.

Composite of cooked retail cuts of beef*

Protein	25.9 g
Iron	2.7 mg
Zinc	6.0 mg
Vitamin B-12	2.28 mcg
Thiamin	.08 mg
Niacin	3.6 mg
Sodium	55 mg
Total Fat	8.7 g
(Saturated Fat)	(3.4 g)
Cholesterol	76 mg
Calories	189

¹ United States Department of Agriculture, “Nationwide Food Consumption Survey, Continuing Survey of Food Intakes by Individuals. (NFCS, CSFII)” Report No. 86-1. *Nutrients in 3 oz. trimmed and cooked. USDA Handbook 8-13, Rev 1986.

PHYSICIAN — FAMILY/GENERAL PRACTITIONER. Applicant must be Board-Eligible or Board-Certified. Chillicothe, Ohio is a 50-minute drive south of Columbus, Ohio, and possesses opportunities for cultural, recreational and leisure activities. Excellent salary and federal benefits. Please send inquiries and curricula vitae to William L. Haskins, MD, VA Medical Center, 17273 SR 104, Chillicothe, OH 45601, (614) 773-1141, Ext: 7717. EOE

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insurance provided and benefit package available. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

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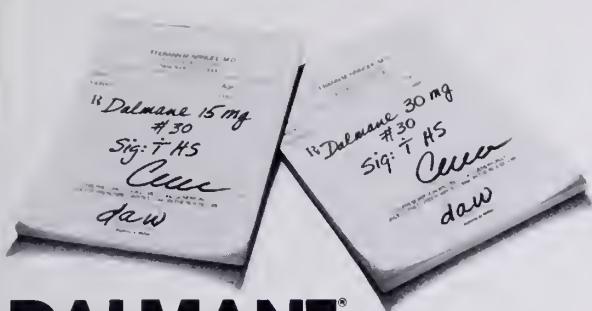
Next month
in

**OHIO
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**Health Care's
Third Party:**

**How Ohio Physicians
Feel About Today's
Reimbursement Plans**



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References: 1. Kales JD, et al: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A, et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A, et al: *Clin Pharmacol Ther* 19:574-583, May 1976. 4. Kales A, et al: *Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLuca MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Dement WC, et al: *Behav Med* 5:25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol* 3:140-150, Apr 1983. 8. Tennant FS, et al: Symposium on the Treatment of Sleep Disorders, teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977.

Before prescribing, please consult complete product information, a summary of which follows:

INDICATIONS: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

CONTRAINDICATIONS: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

PRECAUTIONS: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function. Inform patients to consult physician before increasing dose or abruptly discontinuing flurazepam HCl.

ADVERSE REACTIONS: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

DRUG ABUSE AND DEPENDENCE: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

DOSAGE: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

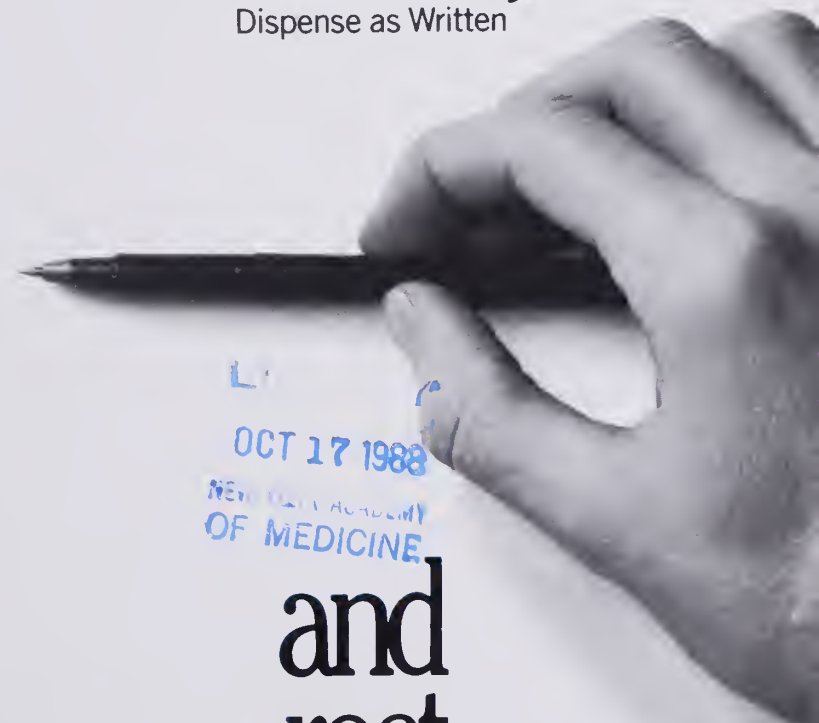
SUPPLIED: Capsules containing 15 mg or 30 mg flurazepam HCl.

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As always, caution patients about driving, drinking alcohol or operating hazardous machinery during therapy. Contraindicated in pregnancy.
Please see preceding page for references and summary of product information.

OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 84, NO. 11

NOVEMBER, 1988

Third-Party Payors:



How Do They Add Up
With Ohio's Physicians?

In the depressed and anxious patient

See Improvement



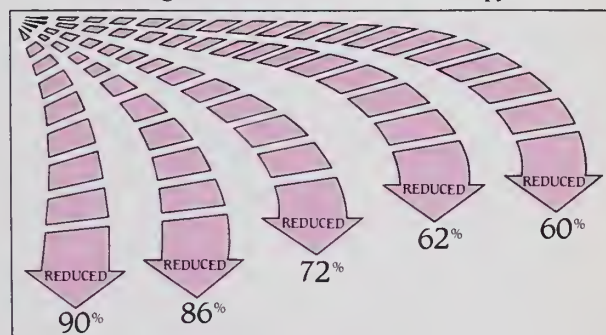
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And The Weeks That Follow

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose¹
- ➡ First week reduction in somatic symptoms¹

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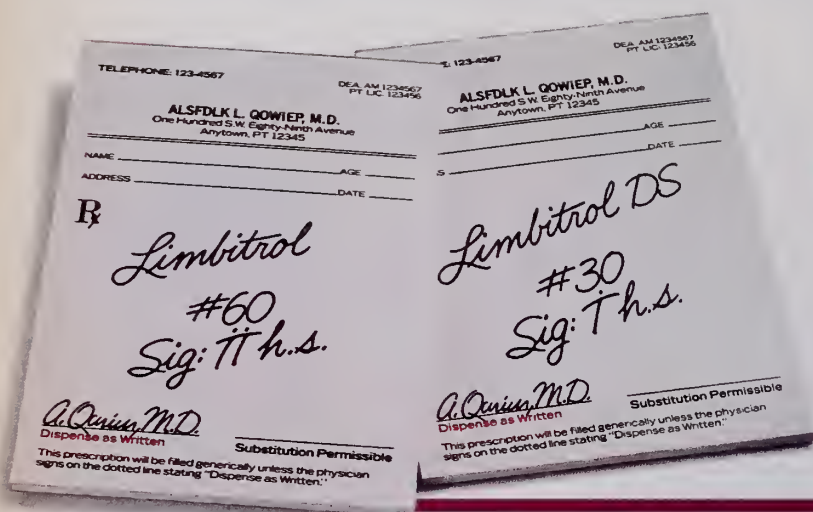
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References: 1. Data on file, Hoffmann-La Roche, Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

Limbitrol® (V)

Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (See Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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FROM THE EDITOR

Government and Third-Party Payors

What do Ohio's physicians think about the third-party reimbursement system? If the focus group interviews that were conducted around the state recently, as a special project of the OSMA, are to be believed, the feelings run high — and our feature article this month describes which way those feelings run. Are you with your colleagues on this issue? Read the article to find out . . .

With the federal government (another popular physician subject) stiffening its control on the quality of work produced by clinical laboratories — can the work done in *physicians'* office laboratories be far behind? The answer is no, and 1990 is the target date set up by those in Medicare to clamp down on the laboratory work being conducted in doctors' offices. What can physicians do *now* to prepare themselves (and their labs) for the coming regulation? Our article, "The Furor in the Laboratory," may give you some clues.

This month's "Ohio Medicine" section features some fascinating stories from around the state — a look at this year's team physician honorees; a Cleveland physician immortalized on a U.S. postage stamp; a computer that allows the patient to see how he or she will look *after* surgery — *before* surgery; and an innovative program that gives minority students an opportunity to pursue medical careers.

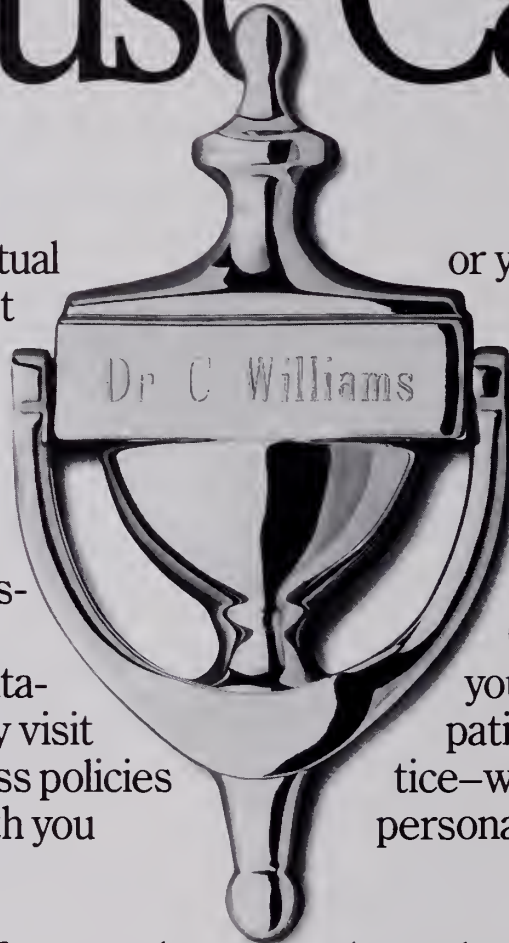
The OSMA's annual audit is also included.

Next month, we'll take a look at the medically indigent here in Ohio — who they are and how they are getting along. Don't miss it!

Karen S. Edwards

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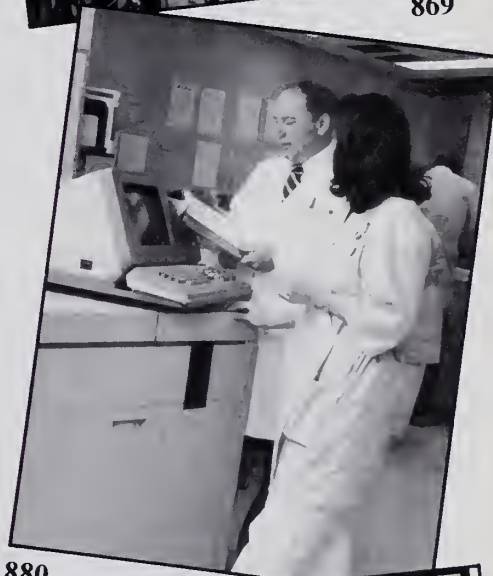
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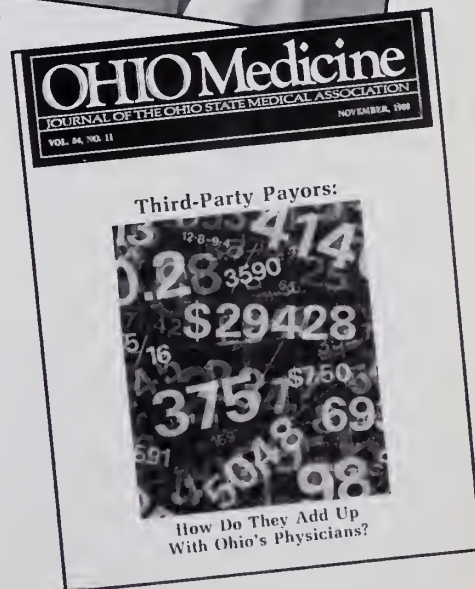
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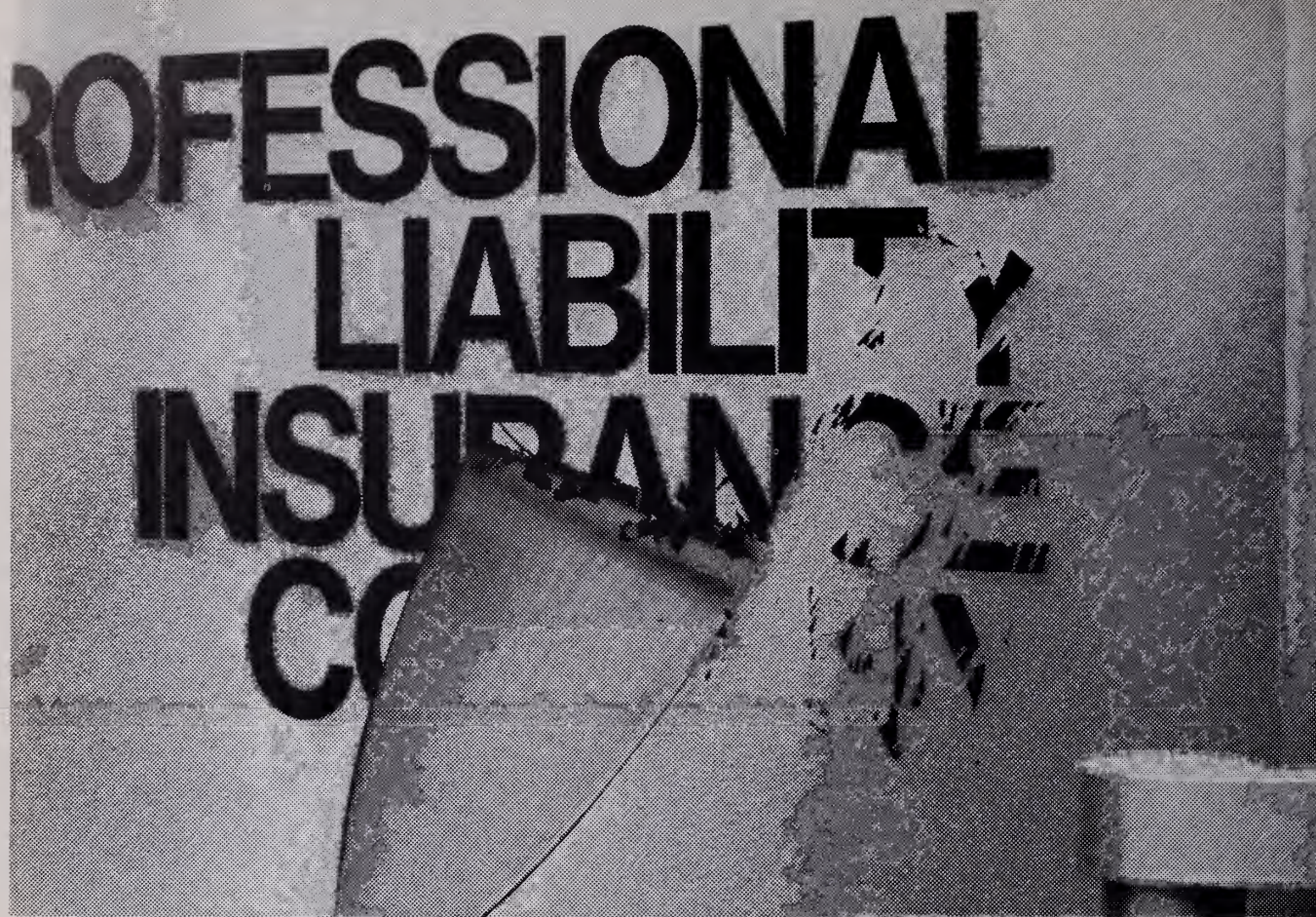
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	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- ◆ Vicodin offers: less nausea, less sedation, less constipation.

**...and longer lasting pain relief—
up to 6 hours.**

- ◆ Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.¹
- ◆ In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.²

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1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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hydrocodone bitartrate 5 mg. (Warning: May be habit forming) and acetaminophen 500 mg.

The original hydrocodone analgesic.

Please see adjacent page for brief summary of prescribing information.



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:
Allergic-Type Reaction: VICODIN contains sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than non-asthmatic people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. (see ADVERSE REACTIONS: Respiratory Depression).

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: As with any narcotic analgesic agent, VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind. **Information for Patients:** VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex, as with all narcotics, caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Use in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1.0 mg/kg q6h, and paregoric 2 to 4 drops/kg q4h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.

Labor and Delivery: As with all narcotics, administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. The antiemetic phenothiazines are useful in suppressing these effects; however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS.)

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use and the incidence of untoward effects is dose related. The usual adult dosage is one or two tablets every four to six hours as needed for pain. The total 24 hour dose should not exceed 8 tablets.

Revised June, 1987

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Next month in OHIO Medicine:

The Medically Indigent . . .

**Who are they and how
are they coping?**



Professional Liability and Double Standards

*By Donavin A. Baumgartner, Jr., MD
President of the OSMA*

You are sold a new battery for your car, only to find that it suddenly dies only two months later, leaving you in a situation of needing to respond to a medical emergency — but no car. After your anger subsides and the immediate situation is addressed, you set out about replacing the battery, only to find that the supplier feels the manufacturer is responsible and the latter returns you to the supplier who then explains that only a small fraction of the cost is covered due to the long time you have had the product.

A furnace fan is installed in a home which blows ashes throughout the house and is later discovered to be in backwards. In addition to aggravation and much cleaning expense, you will be lucky to have even an apology and the matter set right.

A new roof, installed by a company chosen despite its bid being far from the lowest, begins to leak after the first rainstorm. Not only do you have much difficulty obtaining return visits, but you are also faced with having

to make multiple “repairs” which have a final unsatisfactory appearance if not function. I have heard many physicians relate such stories and then add, “If I practiced medicine that way, I’d be sued — and would deserve it!”

Therein lies the problem. Physicians are clearly being held to standards far different from the rest of the population. The legal definition of malpractice has long since been subverted and replaced by “anything less than perfection IN RETROSPECT, is malpractice.” Anyone who doubts this need review only a fraction of the cases filed.

When the local pro football team is in the playoffs and it is third and goal, the coaches and quarterback confer and choose a play that has worked all year. When disaster strikes in the form of an interception, no lawsuit is filed against the coach, assistant coaches, trainer, quarterback, wide receiver and owner. No “expert” (a junior high school golf coach) comes out of the woodwork with a letter indicating that it was obvious that by choosing a different play

(no need to even specify which) the team would have won the Superbowl not only that year, but to a reasonable degree of certainty, for at least the next five years.

No group is held to the standards of physicians even when much more is at stake than a football championship. Investment “advisers” and insurance agents are not. Even when their advice results in financial catastrophe, they seldom are sued, let alone found guilty. The worst case of double standard, however, involves the attorney filing the malpractice case. In most cases there is absolutely nothing to prevent filing a suit with no investigation whatsoever. There are no penalties for naming a physician who clearly was involved only *after* the specific point in question, or to name a physician who was out of town at the time. There appears to be no drawback to suing the radiologist who correctly reads a chest film in a case of appendicitis, and never even saw the patient. Even suing a physician for “failure to make the diagnosis,” when the record clearly not only contains that diagnosis,

but the patient signed out against medical advice, is considered fair game. No matter how outrageous the suit, it is held appropriate as "in the interests of the client." If a physician, in evaluating a patient with abdominal pain, told him that since it was obvious that something was wrong, it would be unnecessary to pursue any tests, and "we'll just operate and see what we can find," that physician would be hung out to dry and would deserve it. Filing a million-dollar lawsuit with no more investigation than listening to a patient should be treated in a like manner.

Last year, changes in Ohio law included an attempt to remedy this, however the mere fact that an attorney has had a "physician examine the record" does not prevent this physician from being his brother-in-law, a physician in a specialty totally unrelated to the case in question, or some other hired gun.

Even in terms of awards, there is a double standard. Many studies have shown that the same specific condition is compensated four and five times greater when due to malpractice than when due to an automobile accident or other action subject to a suit.

Then we have the case of the professional expert. You know who I mean — the individual who is ready and willing to find malpractice in any chart, including his own if you hid the patient's name. Malpractice is supposed to be a failure to adhere to the standard of the average competent physician, NOT what a superspecialist decides he *would have* done in retrospect after all the data not available at the time of the decision is in. Once, when asked to review a case, the mystery deepened with each page of the record, and there was absolutely no clue as to the diagnosis at the time of the patient's death. Asking

a number of physicians renowned for diagnostic ability to review the case revealed that not ONE came remotely close to the eventual diagnosis. The autopsy revealed not only a rare disease, but the clinical course was in no way typical or suggestive of that condition. Nevertheless, the plaintiff produced an "expert" who not only indicated the diagnosis should have been crystal clear, but even suggested a point in time some three days prior to the death when even the janitor would have been able to make the diagnosis. Here again, we see the double standard. In hospital care or in usual medical circles, such an outrageous opinion would be subject to peer review. Not so in the case of these legal opinions by physicians. In most cases, they never have to defend their statements even when they clearly are in conflict with known medical fact.

It is high time that we address these double standards. All the usual tort reform in the world will not address the real problem. All we ask as physicians is that attorneys who file lawsuits be held to the same standards as we are. This is not unreasonable. Asking the courts to change the system is akin to asking the sharks to stop eating the goldfish. Legislative action precipitated by public demand will be the only reasonable pathway but it must be pursued. Physicians who render opinions in malpractice cases must be subject to the same type of peer review as other forms of practice. The AMA House of Delegates has called for testimony of this type to be submitted to the individuals' specialty board for review. This form of double standard must be eliminated.

Equal treatment under the law is a constantly bandied phrase. It is high time it be applied to professional liability. **OSMA**

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Correction

In the article "The Generic Debate" (*OHIO Medicine*, September 1988, p. 730), Janet Bixel, MD, OSMA representative for the Ohio Medicaid Drug Formulary, is quoted as saying that after HCFA removed a number of brand-name drugs from the drug formulary, "The physician community responded with letters and we were able to return these drugs to the list." To be more accurate, says Bixel, "We were able to return the brand-name anticonvulsants that HCFA removed. We were not able to return the brand-name cardiac and psychotropic drugs that HCFA removed."

In the next paragraph, the sentence should have read: "We need to keep Medicaid patient costs down without jeopardizing quality of care."

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine or the Ohio State Medical Association.

Open Advertisements and Medical Care

By Bipin N. Shah, MD

The Central Ohio Urological Society (COUS), composed of 50 members representing 15 counties and the central portion of the state of Ohio, is worried about the trend toward open advertisement noted in the various media in the last year. This subject was discussed in an open forum in two of the Society's recent meetings, all points of view being presented. The Society felt that a stand should be taken publicly to let our patient population as well as our fellow physicians know that the genirourinary surgeons in this area feel that open advertisement is a detriment to good medical care. As a result, the following resolution was approved at our April meeting:

"The Central Ohio Urological Society is concerned about the nontraditional forms of physician advertisement being presented in newspapers, magazines, periodicals, television and radio. These advertisements may result in higher patient costs, dissemination of information about unproven medical

technology, disruption of normal patient-physician relationships and development of physician-physician interpersonal problems. Advertisement may produce unrealistic patient expectations which can diminish the excellent urologic care offered by the genirourinary surgeons in the Central Ohio area."

As stated, this resolution was adopted by the members of the COUS in attendance at the April meeting, but it was felt that presentation of such a position should not be made until all the COUS members had had a chance to comment on this proposal. Thus, the resolution was sent to all members of the Society requesting that they read the proposal and note their approval or disapproval of it. More than 90 percent of the membership responded to the mailing, and only two negative votes were registered. With this strong ratification having been made, it is the Society's feeling that this position should be made public in hopes that our position will serve as a point of leadership

in the medical community. The COUS realizes that it is everyone's right to advertise and it realizes that enormous pressures are being placed on physicians to do so by so-called marketing experts and advertising firms; however, the Society feels that the real winner in an advertising war is the company that convinces the physician to do the advertisement, certainly not the patient who eventually will have to pay for the advertisement in higher charges. It is the hope of COUS that physicians will think about the long-term sequelae of open advertisement and will resist the thought that "If Dr. Jones does it then I have got to keep up by doing it." Then perhaps the art of medicine can be preserved and the thought of medicine as purely a business can be suppressed. It is the hope of COUS that other medical societies will follow the example we hope to set in our membership. **OSMA**

Bipin N. Shah, MD, practices genirourinary prosthesis surgery and endourology in Columbus.

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians



On the first day of Christmas . . .

'Tis the season for catalogue shopping, and practically every large department store in the country has probably sent you its Christmas version by now — but if you're still searching for a unique gift this yuletide — for a colleague, a nurse, or favorite medical student — you may want to thumb through the 1988-89 edition of "The Anatomical Products Catalogue," published by the Anatomical Chart Company.

The 240-page catalogue, weighing one pound, is divided into the following categories: "Charts and Posters," "Models and Training Aids," "Books and Publications," and a section wryly titled "The American General Store." Besides the typical training models and assorted plastic body parts, the catalogue also offers flash cards on human biology, designer elastic bandages, anatomical jewelry and a solid chocolate heart model.

For more information, or to obtain a copy, write: The Anatomical Chart Company, 7124 North Clark St., Chicago, IL 60626. Cost of the catalogue is \$3.

Youthful stomachaches may be result of anxiety

The next time a child is brought to you, complaining of stomachache, and you can't find anything physically wrong, you may want to ask your young patient about his or her anxiety level.

According to findings recently published in the *Journal of the American Academy of Child and Adolescent Psychiatry*, many children who suffer from chronic stomach complaints frequently internalize their problems rather than express them, and end up with stomachaches as a result.

Most of the children studied (71 percent) worried frequently about

their parents, as well as about themselves — over twice as many as usual — but there had been a recent death in the families or among close friends of 55 percent of the patients, which may have contributed to their worrying. Fourteen of the patients had family members with peptic ulcers, which might also explain the children's stomach complaints, because of a tendency to mimic parents' nervous system hypersensitivity. Over 50 percent of the children with recurrent abdominal pain had higher scores on the "internalization scale" as well.

Sleep and the older patient

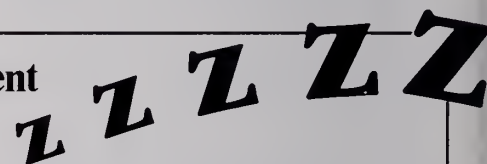
If older patients are complaining to you about their inability to sleep, you might give them the following tips on how to maintain good sleep habits, found in a new, free brochure, "Du Pont Sleep Guide," distributed by the Du Pont Company:

- Go to bed and rise at the same time every day, even if retired — including weekends. This will regulate the natural biological time clock.

- Avoid unnecessary medication, such as the consistent use of sleeping pills. Although mature adults constitute only one-seventh of the population as a whole, they receive one-third of all prescriptions for sleeping pills.

- If sleep is disturbed because of allergies, switch to a non-allergenic pillow or one that provides extra-support. These pillows also contribute to a comfortable sleep environment.

- Don't lie in bed wide awake.



After 20 to 30 minutes of sleeplessness, get up and leave the bedroom. Engage in some other activity, such as reading a dull book or watching old movies on television until drowsiness takes over.

- Room temperature should be slightly cool for comfortable sleeping. Ideally, temperature should be between 64 and 66 degrees.

- It is important to maintain regular schedules and include some physical activity and exercise in the daily routine. Have regular meal times, and allow some time to relax in the evenings.

- Have regular check-ups to maintain good health. Poor sleep may indicate poor health. As health improves, so will sleep.

For a copy of the brochure, write: Du Pont Sleep Guide, Dept. 5119, Ronks, PA 17573.

Another day in medical school ... and deeper in debt

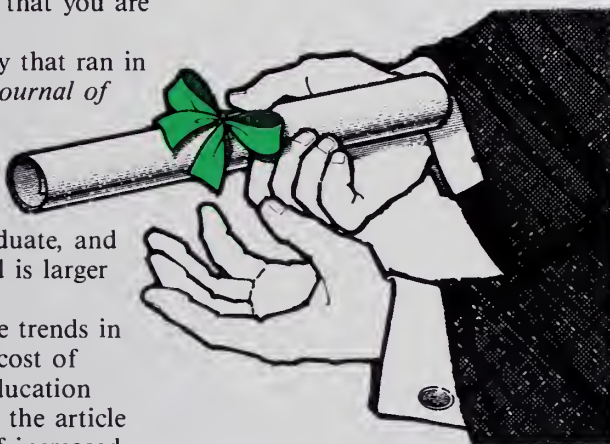
If you're a medical student, chances are very good that you are in debt.

According to a study that ran in a recent issue of the *Journal of the American Medical Association*, eight out of 10 medical students are in debt when they graduate, and their average debt load is larger than ever before.

"Consistent with the trends in higher education, the cost of obtaining a medical education continues to escalate," the article read. "The patterns of increased borrowing by medical students is resulting in higher levels of debt for MD graduates."

The study reports that 82 percent of all 1987 medical school graduates were in debt, owing an average of \$35,621 — more than \$2,100, or six percent, higher than the average debt load of 1986 graduates. Seventeen percent of all 1986 and 1987 indebted graduates owed more than \$50,000, the authors say.

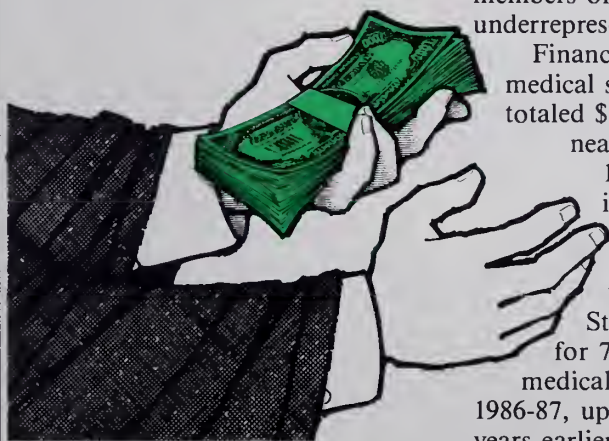
Despite greater levels of indebtedness, it appears that medical students who graduate



owing more money choose specialties similar to all graduates, the authors say. "At this juncture, there is no indication that higher debt at graduation is influencing specialty choice in any unusual manner," they say. "However, heavily indebted students are more likely to be older, female and members of minority groups underrepresented in medicine."

Financial assistance to medical students in 1986-87 totaled \$575.5 million, up nearly 14 percent from 1984-85. Most of the increase was attributable to student borrowing which increased more than 17 percent.

Student loans accounted for 77 percent of all medical student assistance in 1986-87, up from 75 percent two years earlier. Scholarship funds have increased 5.4 percent over 1984-85.



Asthma treatment criticized

Despite its popularity, a drug commonly used to treat severe asthma attacks has been called "not very effective" in a report recently published in the *Journal of the American Medical Association*.

After reviewing and analyzing reports on controlled trials of aminophylline, often used intravenously to treat acute asthma, researchers at Stanford University say they cannot justify the drug's use over other bronchodilators.

In the report, the author, Benjamin Littenberg, MD, of Stanford University and the Veterans Administration Medical Center in Palo Alto, CA, notes that since the introduction of steroids and beta-agonists as alternative asthma therapies, there has not been a reassessment of the risks and benefits of aminophylline, a drug known for its toxicity.

After studying 13 reports of controlled studies that compared aminophylline therapy with epinephrine or other bronchodilator drugs — the only studies available — Dr. Littenberg concluded that, "Aminophylline seems to be a poor choice as a single agent in the treatment of severe, acute asthma."

Those reports showed, among other things, that there was no difference between the aminophylline-treated groups and the control groups and that the drug was not as effective as epinephrine.

"Despite widespread practice and teaching," Dr. Littenberg concludes, "there is remarkably little data on which to build rational recommendations for the use of this toxic drug in this setting."

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OHIO MEDI-SCENE

Computer helps surgeon mold faces . . . poetry in medicine . . . MCO gives students a fighting chance . . . a stamp of distinction . . . team physicians honored . . .

Computer helps surgeon mold faces

As recent as eight months ago, Mark Mandell-Brown, MD, a Cincinnati facial plastic surgeon, was snapping black and white photos of his patients and drawing rough sketches to approximate the effects of plastic surgery.

"It was and still is very hard to demonstrate to the patient how you can change something (using only) a photograph," Dr. Mandell-Brown says now.

That's why in May he tossed out his pencil and paper, picked up an electronic wand, and turned to his new computer screen. By using a system called the McGhan PreView Imaging System, which combines a high-resolution video screen with computer graphics, Dr. Mandell-Brown can now "sculpt" a patient's face before his or her very eyes — in considerably less time than it takes to make a sketch.

"It's just a great asset as far as enhancing communication with the patient is concerned," he says. "We're a visually-oriented society, and for someone who's been contemplating plastic surgery, it gives them a much better idea of what they'll look like. It might even help them decide that (plastic surgery) isn't for them after all."

Larry D. Schoenrock, MD, chairman of the American Academy of Facial Plastic and Reconstructive Surgeons' New Technology Committee, agrees that computer imaging can serve as an

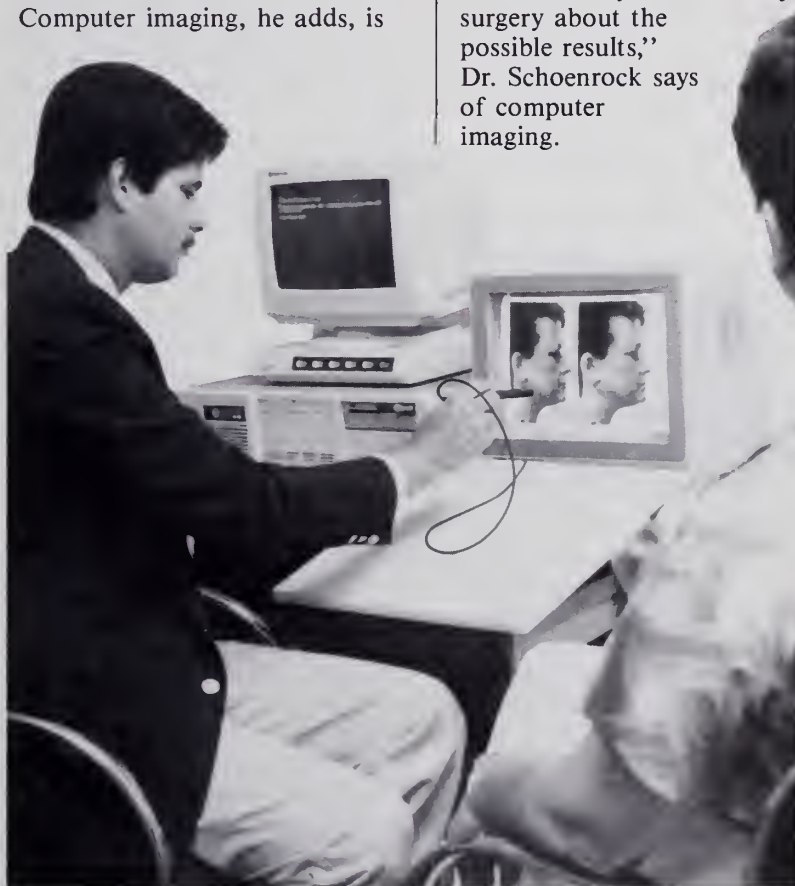
invaluable communication tool where plastic surgery is concerned.

"You can describe the procedure," says Dr. Schoenrock, who has a private facial plastic surgery practice in Santa Rosa, CA, "but if (the patient) can visualize it, it solidifies it in their mind."

Computer imaging, he adds, is

especially helpful when a patient is ambivalent about undergoing a procedure. That is, after viewing his or her computer-generated image, the patient may decide that the pain and expense of plastic surgery are not worth the minimal change it may achieve.

"It allows you to talk *before* surgery about the possible results," Dr. Schoenrock says of computer imaging.



Facial plastic surgeon Mark Mandell-Brown, MD, uses a computer to demonstrate a proposed nose reduction to a patient.

OHIO MEDI-SCENE

Computer helps surgeon mold faces . . . *continued*

For those physicians unfamiliar with such systems, when a patient visits the plastic surgeon for an initial consultation, a video-type camera records the patient's image and reproduces it on the computer screen. The image is then duplicated to provide one "before" image and one "after" image — the image that will be manipulated — on a split screen.

By touching the electronic wand to the computer screen, the plastic surgeon can instantly erase bags under the patient's eyes, shear excess folds of skin, even sculpt new noses. Some systems, such as the one used by Dr. Mandell-Brown, will even match the patient's skin tone, thus providing

the computer "can raise expectations, it can also do the opposite," he says. "Most people use the computer to establish a goal. Most of the time, I can achieve that goal . . . but I have to be careful because some things are harder to achieve in surgery than they are on the computer."

To avoid any problems, most plastic surgeons who use these systems make sure that patients sign disclaimers which state that the computer-generated image is *not* a guarantee of plastic surgery results.

In Dr. Mandell-Brown's practice, not only do patients sign a disclaimer, but one also appears on the video screen at the time of the initial consultation. His patients are also told that several variables may affect the outcome of the surgery — namely the plastic surgeon's ability, the nature of the patient's tissue, cartilage and bone structure, and the patient's natural healing process.

If all this sounds a little hi-tech for the average physician, rest assured that the computer systems currently available — and there are several — have been refined and made more user-friendly than the prototypes that were designed four or five years ago.

And while their use is not widespread, according to Dr. Schoenrock, who has served as a consultant to one of the companies that produces such systems, there are approximately 350 color graphic systems in use in the country, and roughly twice as many black and white systems.

"I think it's coming into vogue, but it depends on the (plastic surgeon's) office," Dr. Schoenrock says, pointing out that the initial outlay for a computer system can be prohibitive for surgeons with small practices (most systems run anywhere from \$8,000-\$20,000).

Some surgeons may also shun the computers, viewing them as gimmicks to attract more patients. Not true, says Dr. Schoenrock.

"It can be like any other mechanism for communication — it *can* be gimmicky," he says, "but if it's used in an ethical way, it can be a very effective means of communicating with the patient."

— Michelle J. Carlson

"This isn't a guaranteed result . . . it's an image for the sake of discussion."

a more realistic effect.

But it is precisely this lifelike effect that can be misleading if the plastic surgeon isn't careful. The computer, Dr. Mandell-Brown emphasizes, is meant only to serve as a visual aid; it is *not* meant to guarantee that a particular procedure will transform the patient into what he or she sees on the screen.

"This isn't a guaranteed result," Dr. Mandell-Brown says. "It's just an image for the sake of discussion."

And while he does concede that

Poetry in medicine

Sometime during the subway rides back and forth from the hospital, or driving home late at night after delivering a baby, or when sitting down for a late supper by himself, William Carlos Williams, a pediatrician from Rutherford, New Jersey, recorded his impressions of the neighborhood, his practice, and the world around him. These impressions secured him a reputation as one of the finest 20th century American poets.

The juxtaposition of these two careers — the writer and the physician — may seem incongruous, but as Williams wrote: "As a writer I have never felt that medicine interfered with me, but rather that it was my food

and drink, the very thing which made it possible for me to write."

Most medical schools now offer students a taste of the literary fruits and humanities as part of their medical education. The rationale is that classes in the humanities give students an expanded view of their profession and what it means to be a physician.

This sojourn in the humanities is "a defense against the narrowing effect of medical education . . . just looking at a medical practice through a scientific filter and seeing patients as body parts or organs," says Martin Kohn, director of the Human Values in Medicine Program at the Northeastern Ohio Universities College of Medicine (NEOUCOM). "We attempt to make the picture whole again, and to show how the patient fits into a historical perspective, the community and the family."

The Human Values Program in Rootstown offers 40 to 50 courses and workshops in which books, case studies, poems and articles are read and critiqued. The classes are steered away from the proverbial rote memorization and recital routine and geared toward open discussions, journal-keeping and reflection.

The program differs from those at other universities in that the humanities courses are usually required in the student's *senior* year, "after they've been transformed by their clinical work. They have realized their newfound responsibility and the gravity of what they're doing," Kohn says.

The Cleveland Clinic's I.H. Page Center for Creative Thinking is taking the humanistic trend in medicine a step further — maybe to its logical conclusion. The center, named for Cleveland physician Irvine H. Page, MD, has now set in motion a *post-graduate* humanities and medicine education program.

Clinical Classics

"The Plague" — Albert Camus

"Arrowsmith" — Sinclair Lewis

"The Use of Force" — William Carlos Williams

"Frankenstein" — Mary W. Shelley

"The Metamorphosis" — Franz Kafka

"A Burnt-Out Case" — Graham Greene

"The Death of Ivan Ilych" — Leo Tolstoy

"The Doctor's Dilemma" — George Bernard Shaw

"An Enemy of the People" — Henrik Ibsen

"The Death of Bessie Smith" — Edward Albee

Selections compiled from an article in *Massachusetts Medicine* (Nov/Dec 1986) and conversations with Steven M. Radwany, MD, an Akron internist, and Martin Kohn, director of the Human Values in Medicine Program at NEOUCOM.

According to the director of the I.H. Page Center, Shattuck W. Hartwell, Jr., MD, the program is designed to present issues affecting medicine from broad, varied perspectives. As a brochure for the center points out, "There must be a bridging of the cultural gaps that have separated the sciences. The integration of these areas of learning — once a matter of leisure, luxury and taste — is, this late in the 20th-century, imperative for the survival and well-being of humanity."

"Many of us let areas of our brain wither," Dr. Hartwell says. "We become very busy prescribing the right dose and the right operation, but we're only using a certain corner of our brain. We need to sharpen up those other processes of thought."

The first phase of the program kicks off in October/November 1988 and focuses on medicine and the humanities, including literature,

science, philosophy and religion. Seminars on these topics will be taught by John Carroll University faculty.

The classes will be kept small — enrollment is limited to 15 — and like the medical school prototypes, will concentrate more on discussion than on lecture. "We want to encourage a way of thinking and interacting that should be refreshing to physicians," Dr. Hartwell says.

"There are enormous areas of inquiry that medicine can address," he continues — topics that the Page Center has been delving into since its opening in 1987. "The rationale is that medicine is bound to be responsible socially to the public."

Steven M. Radwany, MD, an Akron internist, got his first taste of the humanities and medicine courses during a residency in Illinois. "The most agreed-upon thing was that everyone enjoyed it. We got to read some very fine works of literature and discuss them among a very interesting group of people."

Beyond this, the exchange of ideas opened other channels of communication as well. A dialogue developed between a variety of medical personnel who were taking the class — residents, nurses, social workers — regarding what was going on inside the hospital. "We achieved some insight into what we do every day through the eyes of some very insightful authors."

Because the students discussed hypothetical situations that occurred in literary classics, the talks were relatively safe, he explains. "They weren't issues in which we had current emotional investments. We were talking about idealized settings, not specific cases which could inhibit the setting and generate bad feelings."

Some of the books that made an impression on Dr. Radwany
continued on page 867



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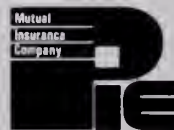
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Poetry in medicine . . . *continued*

include:

"Frankenstein," by Mary Shelley. This novel epitomizes the impact of technology on medicine, says Dr. Radwany. "Sometimes technology is applied in such a way that it's almost gotten beyond our control. 'Frankenstein' is a picture of science and progress out of control." Although technology is pushed to a monstrous extreme in this famous story, it is still a very topical issue in medicine, he says. "Technology has advanced to the point that sometimes we're not sure how to apply it ethically," he points out.

"The Metamorphosis," by Franz Kafka. This short story offers an unusual look at how caregivers and family respond to terminal illness, as well as how the patient sees himself, Dr. Radwany explains.

"The Peloponnesian War." This beautifully written piece of literature recounts the response of physicians to the plague in Athens, says Dr. Radwany. In some ways, their response might be paralleled to the modern-day physician's reaction to AIDS, he says, and perhaps we can learn something.

"The Use of Force," by William Carlos Williams. One of the stories in this collection is "The Doctor Stories," says Dr. Radwany. "I read it over and over. In order to work with a patient, we sometimes have to inflict pain. He (Williams) captured that and his own discomfort with that so well. It's something that we're sometimes troubled by," he continues. "We can't take time to think about it so much when we're treating the patient, but it's good to think about it afterward, when we can justify the use of force."

Physicians are under constant pressure to keep up with the latest in medical scientific information, says Kohn. "The humanities classes are a kind of counterbalance, a reminder that says, 'Remember the bigger

picture.' We don't want to do this at the expense of their scientific base, but in a complementary way. It's the occasional recurrent reflection that's important," he says.

As medicine becomes more technical, the way that physicians use the tools of the trade becomes more important, too, he says. "The tools still need to be used in an interchange with patients, and it's the nature of the exchange which is important."

This relationship "doesn't need to be pre-empted by the wizardry of the techniques," he continues. "There are those (doctors) who will succumb to the wizardry and others who will maintain healthy, healing relationships with their patients."

But Kohn is optimistic about the patient-physician relationship. "As I'm going out on the floor, I'm very impressed by what I see," he says. "I think the uncaring physician is the exception."

A good number of physicians are already operating in a moral, ethical way, Dr. Radwany agrees, but they may need an opportunity to reflect upon this. "We may learn to ask ourselves more questions and to reflect more, and maybe that will change the way we practice," he says.

There has been a long tradition of writing physicians — Chekhov, Conan Doyle, Somerset Maugham — and writing about physicians. "Writers make use of a tool that doctors use as well, and that's *distance*," Kohn says. There are more similarities between physician and writer than may at first meet the eye. "The scientist and the artist both depend on imagination and vision," he points out.

William Carlos Williams described his years as a physician as "a lifetime of careful listening." In essence, Kohn says, that's what the poet does as well, but the physician also hopes to heal. — *Deborah Athy*

William Carlos Williams Poetry Competition

The Human Values in Medicine Program at the Northeastern Ohio Universities College of Medicine is sponsoring its seventh annual poetry competition for U.S. and Canadian medical/osteopathic students.

"The physician is often thrust into real-life situations where there is a lot at stake," says Martin Kohn, director of the Human Values in Medicine Program. "Many of them are moved by what they see and may want to share their experiences. This poetry contest is to reward those who pursue this avenue of expression."

The deadline for submissions is December 31, 1988 (open for *students* only). For more information, write Human Values in Medicine Program, Northeastern Ohio Universities College of Medicine, P.O. Box 95, Rootstown, OH 44272 or call (216) 325-2511.

MCO gives students a fighting chance

Every year, for reasons ranging from inferior grades to fierce competition, thousands of college graduates are denied admission to medical schools all over the country. But now, students who might not otherwise have been accepted into medical school are being given a chance to prove themselves by participating in a unique program at the Medical College of Ohio in Toledo.

The program, which has been dubbed the Flexible Curriculum Program, allows students who are considered "educationally disadvantaged" to pursue their medical studies at a slower, less

OHIO MEDI-SCENE

A fighting chance . . . *continued*

intense rate in order to sharpen skills in areas in which they may be lacking.

The so-called disadvantaged student, says Barry Richardson, MCO's associate dean of minority affairs and an associate professor of physiology, is one who, for economic or other reasons, has not had the same educational opportunities as his or her peers. These students, he says, are well-rounded, but may be lacking in one or more areas that medical schools consider crucial.

"The students we look at may have some encouraging aspects," Richardson says, "but they leave you with the sense that they're underprepared . . . We're looking for a spark of promise."

For the school's pilot program, which begins this month, the college's admissions board chose five such students to participate out of approximately 85 students whose admission had been deferred.

"We're looking at the close-but-not-quite student, so to speak."

The students, Richardson says, were chosen on the basis of their economic status, scores on the medical college admissions test and overall promise.

Students were also considered on the basis of their ethnic origins, Richardson says, because the Association of American Medical

Colleges has established that certain minorities — namely blacks, American Indians, Puerto Ricans and Mexican Americans — have a distinct disadvantage educationally when compared with their white counterparts.

"The students in those (minority) cases, we take a close look at," Richardson says. "Other students we look at case by case."

However, he adds, "Although we look closely at these under-represented groups, a white male could get into the program, too. There are a lot of variables."

Admittedly, most of the students considered for the program showed a lack of science skills — which is a major component of any medical college's curriculum — but by no means are these students considered undesirable or unqualified, Richardson says.

"You have to remember that we're not talking about students who have bombed out," he says. "They're just short of getting accepted . . . We're looking at a student the admissions committee has placed on hold. We're looking at the 'close-but-not-quite' student, so to speak."

And therein lies the thrust of the program: Instead of requiring these students to immediately carry a full load of science courses, they are gradually introduced to the rigors of medical college.

For example, while most medical students at MCO are required to take gross anatomy/embryology and biochemistry during their first quarter, students in the Flexible Curriculum Program will take

gross anatomy/embryology and a study management course. Biochemistry will not even be introduced until the second year of study.

The program allows "educationally disadvantaged" students to pursue medical studies.

Another difference between the two courses of study is that students in the Flexible Curriculum Program will participate in faculty-led discussion groups called tutorials, which should better aid the students in grasping basic sciences. Also, in their second year of study, students will take part in a faculty-mentor program, which, according to Richardson, is meant to give students "the opportunity to identify a faculty member with whom they're involved in a research project. . . . We want to give them an opportunity to do research with the faculty and to develop a feel for the scientific process as it pertains to medicine."

Of course, the drawback to such a planned course of study is that students will take three years to move through basic science courses and two years to complete their clinical studies — for a total of five years of study instead of the normal four. But, Richardson adds, in anticipation of the financial strain a fifth year is apt

to pose, MCO is considering waiving tuition during the first year, so students would only be responsible for their room, board, books and other expenses.

Because the program is so unique — Richardson could name only one other school with a similar program — administrators at MCO are uncertain how the program will progress.

"This is our pilot effort,"

Richardson reminds us. "We're starting with five students, then we're going to evaluate the program and make decisions about the curriculum.

"Right now we're interested in maintaining the quality for five students," he continues. "Once we're sure the quality is good, then expansion may be up the road. But we didn't start out saying this year we'll have five, next year we'll have

10, then 15."

With the future of the program up in the air, it may be a little early to make any predictions, but Richardson will offer this: "I think (the program) speaks for itself," he says. "I'm actually expecting the students to come out of this with a very positive feel for their experience. I'm anticipating that it's going to be a good experience." — *Michelle J. Carlson*

A stamp of distinction

It all started quietly enough at a Cleveland book club.

Without much pomp and circumstance. Without much ado.

Russell Hardy, MD, and Robert Cheshire, both from Cleveland and both members of the Rowfant Club — a book club meaning *red earth* and named for a minor Victorian poet — hit upon a ripe idea.

The book club decided to re-issue a book that had previously been published in 1945 by the renown American physician Harvey W. Cushing, MD. The book, "A Visit to the Le Puy-en-Velay," was a collection of essays and illustrations by Dr. Cushing about a particular area in France.

It seemed the right time to blow the dust off the original novel, to give the book an updated look with fresh pages. Dr. Hardy and Cheshire co-wrote an introduction to the book and it was reissued in 1986.

But Dr. Cushing's name and reputation were not ready to be immediately reshelved. Around the same time, he was also chosen to be commemorated on a U.S. postage stamp.

"By pure chance, the (former) president of the American Association of Neurological Surgeons (AANS) was interested in stamps right at the time when we were working to republish Dr. Cushing's book," explains Dr.

Hardy, a professor of neurosurgery at Case Western Reserve University of Medicine. "The book and the stamp happened around the same time."



Photo by Berni Rich, Score Photographers. Used with permission of Cleveland Physician.

The AANS, the U.S. Post office and the Cleveland Medical Library Association combined efforts to honor the late Dr. Cushing, who is considered by many to be one of the top U.S. physicians of all time.

He was the first physician to make neurosurgery a great discipline, says Dr. Hardy, and he continued to be a dominant figure in that field for 20 years. "He greatly contributed to our total understanding of the profession."

Harvey Cushing, MD, was something of a Renaissance man — a great academian, a graduate of Yale and professor of surgery at Harvard Medical School, a renown neurosurgeon, an accomplished artist, and an excellent writer who received a Pulitzer-prize for his two-volume book on the internist Sir William Oster.

Here was the greatest surgeon of the day taking time out to write a Pulitzer prize-winning account of one of the great internists of the day — on top of all his other accomplishments, points out Cheshire, Director of the Cleveland Health Sciences Library. It's just one more reason that Dr. Cushing is a fitting choice to be one of the American "greats" commemorated in the U.S. Postage Stamp Great American Series, he adds.

As a prelude to the commemoration, a ceremony was held at the White House, no less, *continued on page 871*



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A stamp of distinction . . . continued

with Dr. Hardy in attendance. A bust of Dr. Cushing, which was sculpted by a neurosurgeon, was unveiled, and it became the model for the Harvey Cushing stamp.

"The Reagans have some association with neurosurgery," Dr. Hardy explains, because Nancy Reagan's stepfather and brother are both neurosurgeons.

The actual stamp commemoration took place at the Amasa Stone Chapel at CWRU in Cleveland. "It was natural that the ceremony should be held in Cleveland," says Cheshire. "Dr. Cushing was born here and is buried here. This is where he started."

Dr. Cushing's father and brother — both physicians — also had a long tradition in Cleveland, he continues. In fact, his father was a member of the Rowfant Book Club!

During the ceremony, there were speeches by stamp collectors, postmasters, and by former AANS president Robert Ojemann, MD, a stamp lover who was instrumental in the whole event, says Dr. Hardy. There were also exhibits at the Allen Memorial Hospital Library, which was dedicated by Dr. Cushing in 1926.

One of the highlights of the event was a talk by Mrs. John Hay Whitney, Dr. Cushing's last surviving daughter, who shared some reminiscences about Dr. Cushing, the family man.

All of the Cushing daughters married well, and they enjoyed some of society's limelight as debutantes in the '30s, Dr. Hardy adds as an aside. In fact, Dr. Cushing recently received a mention in an article about the writer Truman Capote. Seems that Capote, who earned a reputation for hobnobbing with the rich and famous, befriended one of the Cushing daughters, Barbara Paley. The article alludes to Dr. Cushing's expertise in the medical field, as well as his strong standing in Boston society.

Thus, Harvey Cushing, MD, is being remembered on a number of different fronts. One of the more

lasting is the blueprinted stamp issued on June 17, 1988, which can be acquired for a mere 45 cents. In this way, the Ohio-born physician joins the ranks of other

"Great Americans" honored in the series, such as Dr. Paul Dudley White and Knute Rockney. And the rest, as they say, is history. — *Deborah Athy*

Team physicians honored



Recipients of the 1988 Ohio Outstanding Team Physician Awards, l. to r.: Ralph Rasor, Jr., MD, Van Wert; David D. Clymer, MD, Lexington; Elias Freeman, MD, Cadiz; P.S. Test, MD, Mansfield; and William A. Myers, MD, Circleville. Not shown is Grant Dowds, MD, Shelby.

Six physicians have been named "Ohio Outstanding Team Physicians" for 1988 by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and the Ohio School Athletic Association.

The following physicians were honored in ceremonies July 14 in Canton: David D. Clymer, MD — Lexington High School, Lexington, Ohio, 25 years of service; Grant Dowds, MD — Shelby High School, Shelby, Ohio, 20 years of service; Elias Freeman, MD — Cadiz High School, Cadiz, Ohio, 30 years of service; William A. Myers, MD — Circleville High School,

Circleville, Ohio, 20 years of service; Ralph Rasor, Jr., MD — Van Wert High School, Van Wert, Ohio, 28 years of service; P.S. Test, MD — Mansfield Senior High School, Mansfield, Ohio, 33 years of service.

Presenters from the Joint Advisory Committee were Michael J. Vuksta, MD, Youngstown, chairman; Robert C. Erickson II, MD, Massillon; and Richard Armstrong, Columbus, commissioner of the Ohio High School Athletic Association.

This marks the 14th year that the awards have been presented in conjunction with the Ohio High School Football Coaches Association Hall of Fame Banquet.



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Editor's Note: In the fall of 1987 the Ohio State Medical Association retained a private consulting firm to provide qualitative research that would allow the officers and councilors to determine the positive and negative aspects of third-party payor systems currently in the Ohio marketplace. OSMA's interest in the problems its members are experiencing with managed care programs stems from the association's ongoing commitment to serve its members in the most effective ways possible. Printed below is an overview of the results of the survey.

OSMA believes it is important to understand the relationship of its members to these programs and to address issues, concerns and problems.

This was accomplished with the sponsorship of six focus groups; five with physicians and one with practice managers. The participants were randomly selected from (1) a list provided by OSMA which contained names previously selected at random and (2) the membership directory of the Ohio Medical Group Management Association (OMGMS) from which random selections were made. Some 50 physicians and 10 office managers participated in three different Ohio locations: Columbus, Cleveland and Canton.

The objectives were as follows:

- *Determine the general attitudes, both positive and negative, of participants in third-party payor/managed care programs.*
- *Determine and establish priorities of items viewed as critical problems.*
- *Determine what specific actions can be taken on behalf of the Ohio State Medical Association to address the concerns of its members.*



Third-Party Payors

How well is the reimbursement system working in Ohio? Here's what some of the state's physicians are saying . . .

It is no exaggeration to say the physicians interviewed are unanimous in their opinion regarding third-party payors. If it were possible to return to the former system of fee-for-service medicine, they would elect to do so — immediately. Their opinions about the present system of PPOs (preferred provider organizations), HMOs (health maintenance organizations) and IPAs (independent practice associations) are fraught with frustration, anger, and in many cases, outright hostility. However, while recognizing the present medical environment, those interviewed grudgingly accept the system, but are adamant about the need for improvement and even a redesign of the system. Their concerns for the future of medicine are enumerated repeatedly with specific examples and comparison to the type of medicine practiced in Europe, specifically England.

The complaints and concerns primarily fall into eight categories which follow. The attitudes and opinions of the physicians as a whole were consistent and closely aligned with those of the office managers. While there were some differences among focus groups in the three locations — Columbus vs. Cleveland vs. Canton — they were subtle.

Section One

Findings Within the Eight Problem Areas

Financial Difficulties

The participants are finding increased difficulties in receiving payments for their services. They believe they have discovered intentional delay on the part of the payors, both private and public. The delay can be outlined as a four-step process. Step One — The insurer will not accept the claim form as being complete.

Step Two — The insurer returns the form citing an error or requesting additional information. Step Three — The physician attempts to correct error and/or submits additional information. Step Four — Claim form is returned to insurer.

This is a simplified version but one experienced repeatedly by the physician and his/her staff. Each step is time consuming and represents numerous telephone calls between the insurer and the physician's office. This results in considerable delay in receipt of payment; one physician claims upwards of 14 weeks. Ninety days is the general rule for payment by these programs. In the past, this would be the timeframe in which the physician would turn the bill over to a collection agency. Now, however, the insurance company is the offender so the physician is unable to assign the bill to a collection agency until 90 days plus. The physician accumulates accounts receivable and cash flow is impaired.

Differences in payment have complicated office procedures and require a knowledgeable staff and often an increase in the number of staff in the physicians' offices. The requirement of each insurance company differs and if a physician is not in compliance he risks loss of payment.

It should be noted here that all physicians are not equal. These new payment systems seem to be particularly difficult for the physician who has a small, solo practice. His or her office is usually not computerized and staff's resources are limited. Add to this the physician whose practice is primarily medical-assistance patients and we see a practice in which the cash flow is severely handicapped. Physicians end up asking themselves, "How can we continue to serve this particular patient population?"

By the same token, all medical specialties are not equal. Physicians in emergency medicine, critical care and obstetrics note they have no choice but to accept payment, for they often cannot collect up front.

The schedule of fees established by the third-party payors was also a hotly contested issue. Physicians are no longer content with a general range of fees, and are becoming more insistent on learning the exact fee for a procedure. When a physician signs a contract rarely does he know what percentage in reimbursement will mean in exact dollars. This presents difficulties for the physician in setting his fees and transfers part of the cost of serving the third-party payor patient to the patient who pays cash.

Standardization of Forms

If there is a universal complaint it is the absence of standardization of claim forms. Physicians and their staffs resent the expense and time required to process a variety of claim forms which essentially seek the same information. The administrative costs of maintaining the physician's office staff increases in direct proportion to the mountain of paperwork described by the participants.

Some physicians have solved this problem; others have not. It seems that the American Medical Association (AMA) faced a similar problem a few years ago and resolved it by having the insurance companies agree to accept a form the AMA had designed. Now, however, many of these new third-party payors say they will not accept this form, but insist the physician use a company form. Physicians have flatly refused to comply and inform the payors that the necessary information is contained on the AMA form. They feel their stance and battle was worth the effort.

Managed care tends to mean very different things to different people.

Unification of Codes

There is a layered effect in the need to gain acceptance of a standardized form by the third-party payors. The next layer of frustration is the use of different codes for similar procedures. The physician and office staff spend countless hours updating themselves. If this is not done it results in billing errors and delays in payment.

One physician views billing and coding as a game, for every insurance company is different and each requires a different code for each procedure. A major contention among the participants is the inconsistency in the definitions of these codes. This complicates matters, for the definitions can be applicable to more than one procedure and the insurance company often will not inform the physician what he may bill for. While the CPT book is a good reference for procedures, it does not address many other things.

Contract Review and Comparison

Physicians and their practice office managers continue to feel victimized by the third-party payor system; the primary weapon used against them is the contract. Throughout the focus group sessions, it became increasingly clear the participants believe the following:

- To practice medicine, a physician has little choice but to join a managed care program.
- The programs control the volume of patients seen by a physician.
- The programs usually begin by providing reasonable service to the physician, offering a preferred contract, establishing exclusive access to patients or a share exclusive market, acceptable reimbursement and a timely payment program.
- Once the program has been successful in attracting a

number of physicians, employers and members, it begins to deteriorate.

- Patients often over-utilize programs as they believe they were promised every medical service desired.
- Programs can no longer provide all of the medical services promised and begin to lose money.
- Physicians are then targeted as possible financial underwriters of the program and fees are further discounted.
- Patient/user becomes disillusioned and an adversarial relationship develops between the physician and the patient, as the patient believes the physician to be at fault.
- Patient frequently exercises right to switch plans to capture the best in benefit packages.

What all of this adds up to is a physician who feels he must participate in practically every contract offered, but has no way of judging the benefits of participation. Participation in the contract frequently puts the physician at risk because of pre-authorization, pre-certification requirements, second opinion, referral reserve and retrospective payment denial. The financial risk, once that of the insurer or patient, now lies with the provider.

The patient believes the physician or staff should have the ability to answer questions regarding extent and payment of coverage. The patient also believes the responsibility to collect a claim is that of the physician and the staff. The reality is that neither the physician, the staff nor the patient truly understand the content of the third-party payor policy or contract.

Upgrade Third-Party Payor Staff

The physician and/or staff have been forced to accept administrative responsibility for the contract or sacrifice patients and

subsequent income. To expedite contract problems the physician and/or staff must, with increasing frequency, turn to the program administrators for assistance. Gaining entry into the program is critical but the person provided by these programs is often less than helpful. There are universal complaints, regardless of the program, involving these individuals:

- They are trained to say no.
- Rarely is there an opportunity to talk with the same individual for consistency and follow-through. Telephone inquiries are accepted on a rotating basis and the caller's question is attended to in that manner.
- Should a caller discover a good account representative, it is not uncommon to learn the individual has left the company, is on vacation, is never available, etc. Therefore, the problem is left unattended and the caller must begin anew.
- Program staff members are not medically trained, yet are in fact dispensing medical decisions in accord with the program's requirements.
- While all programs seem to share the problem of needing knowledgeable staff, some programs seem to be worse than others.
- By accepting the decisions of non-medical persons associated with the third-party payor programs, physicians are forced to practice a type of medicine they believe to be unethical. Physicians must now put economic decisions into the medical process.
- The person making judgment in retrospective denial cases is often not qualified. In the appeals process it is rare to have the same person involved who denied payment or approval. Physicians and staff claim that to seek a more qualified person

continued on page 878

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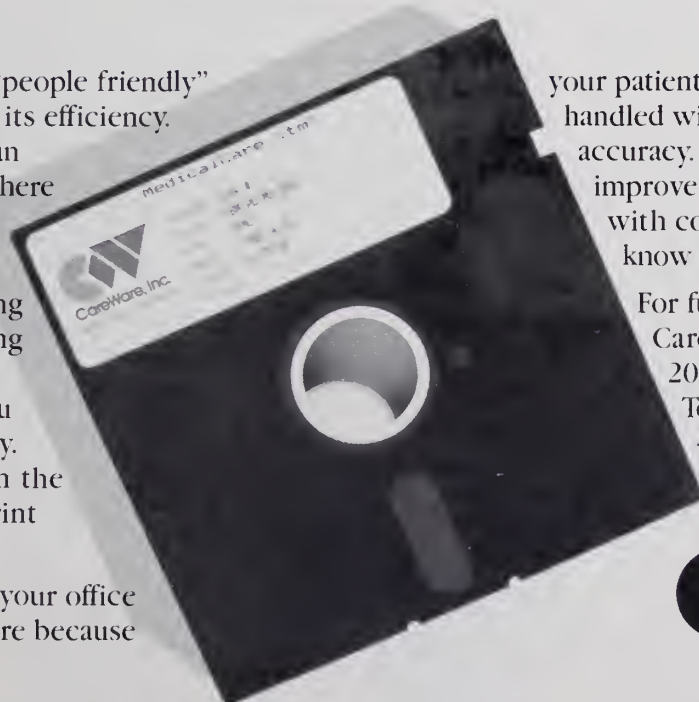
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would further delay the process in which they have already invested a sizeable amount of time.

Standardize Coverage

This difficulty is again contract-related. A recurring situation is the lack of understanding of coverage on the part of the patient/user. This manifests itself when the patient presents himself/herself to the physician who is forced to accept responsibility in administering the contract provisions. Physicians and staff are caught in a revolving door of contract changes; authorizing tests or hospital admissions and having that authority challenged or denied; remaining alert to a variety of benefits provided to different employees or employee groups by the same employer; and patients moving from plan to plan and not informing the physician or understanding limitations of the new plan. When these problems are multiplied by 12 to 30 plans in which a physician participates, the problems are magnified beyond any acceptable degree.

Education of the Patient/User

Managed care as a recent addition to the health-care provider scene is viewed with confusion and is accepted with either reluctance or pleasure depending upon the individual. Contract provisions and the system itself is complex and confusing to the physician, staff and especially to the beneficiary. Managed care tends to mean very different things to different people. And this becomes the crux of the problem.

Patients believe their programs are all-inclusive and this raises expectation levels. Employers often do not explain the programs well. Their agenda is to control corporate health costs. The program managers, as mentioned earlier, are either difficult to reach or not totally knowledgeable. This

leaves the need for understanding the provisions of the policy by the consumer unattended. The scenario that often results is that a patient insists a benefit is provided and a physician has the unhappy task of informing the patient the benefit's not covered. The patient believes this is the fault of the physician, not the employer or the third-party payor, and the relationship between the patient and the physician becomes strained.

Restoration of Physicians' Authority

The way the managed care programs are currently designed, the physician has become a secondary partner, albeit, often an unwilling partner. As one participant stated, "The insurance company is more of a partner in the physician's business than he really desires." There was a great deal of resentment expressed in the focus groups as the physicians believe they are working for the insurance company, not themselves. They proved this in their minds by posing the following questions:

- Who pays the bill?
- Who do you call to get the patient admitted to the hospital?
- Who sets the fee?
- Who says how long the patient can stay in the hospital?

Physicians increasingly view their role as one of a technician — and they resent it. They believe the insurance company has the advantage, for the physicians are essentially a group of small businessmen who are not organized or able to express their dissatisfaction in any collective manner. **OSMA**

A future issue of OHIO Medicine will carry the results and recommendations of the research firm.

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By Karen S. Edwards

The Furor Over Physicians' In-Office Laboratories



Photos courtesy of Kodak.

Will the threat of regulation force physicians to give up their in-office labs . . . or improve them?

If you happen to be one of this country's approximately 100,000 physicians who maintains an in-office laboratory — or you've been thinking about setting up such a lab in your practice — maybe you should be concerned about the recent regulation drafted by the Department of Health and Human Services which forces hospital and independent laboratories to improve the accuracy and quality of their medical tests, or risk removal from the government's Medicare-Medicaid program.

The reason you should be concerned? Very simply, *you* could be next.

In fact, according to William L. Roper, administrator of the Health Care Financing Administration (HCFA), physicians' office laboratories only narrowly escaped being included in the regulations *this* time around.

"Since we do not have enough information on physician-office laboratories, they have been left out for now," he has been quoted as saying.

However, such an omission is unlikely to reoccur in the future, or, more specifically, by January 1, 1990, when Congress, through a provision of its all-encompassing OBRA-1987, has mandated that **ALL HIGH-VOLUME PHYSICIAN OFFICE LABORATORIES PROVIDING MORE THAN 5,000 TESTS A YEAR** meet existing independent clinical laboratory requirements — including personnel standards that would force physicians to hire either a pathologist or a PhD scientist to work as their in-office lab director.

"The various requirements would virtually eliminate the ability of most physicians to maintain or establish office clinical laboratories," said AMA President Alan R. Nelson, MD, in testimony before the Health and Environment subcommittee of the

House Energy and Commerce Committee, which recently held hearings on the issue.

The AMA is hoping to eliminate the proposed regulation by calling for other mechanisms that would assure the quality of in-office laboratory testing.

No one, after all, is against the idea of quality control in office laboratories, and there are those who believe it is high time for such action.

"Ohio has never had any form of mandated quality control for clinical laboratories," says Norman Somerson, a microbiologist and a professor in the Department of Medical Microbiology and Immunology at Ohio State University. Somerson, along with Keith Richardson, a biochemist and vice chairman of the Department of Physiological Chemistry at OSU, serve as consultants to the Ohio Department of Health, which is charged with administering the federal government's Medicare-Medicaid programs.

"The Clinical Lab Improvement Act does ensure that quality work is being performed by laboratories which receive samples for analysis across state lines," says Richardson — but he is quick to point out that not much work ever leaves the state.

Current statistics, in fact, seem to reveal that most lab work never leaves the physician's office.

According to Somerson: "It's estimated that 60 percent of all lab work done in this country is being done in physician offices."

And there is little wonder that it is.

Consider the advantages an in-office lab offers: convenience for both patient and physician, quick responses to difficult questions — and, for a few physicians, a small profit as well.

Besides, it's hard to ignore those slick, promotional pieces the lab equipment manufacturers are

dispensing to physicians by the mailtruck-full. You've probably received one yourself, and been tempted by all those machines that teeter on the cutting edge of the latest technology, yet are neatly streamlined to fill a space no larger than a rather commodious closet. Some manufacturers will even *give* you their equipment — free of charge — banking on the fact that you'll be buying their reagents from them in the years ahead.

No wonder, then, that the number of in-office laboratories has increased dramatically over recent years, and maybe it's only natural that concern for the quality of the work produced in these labs has risen proportionately.

What *types* of things are causing concern?

Somerson and Richardson, both of whom conduct lab inspections for the state, suggest several things.

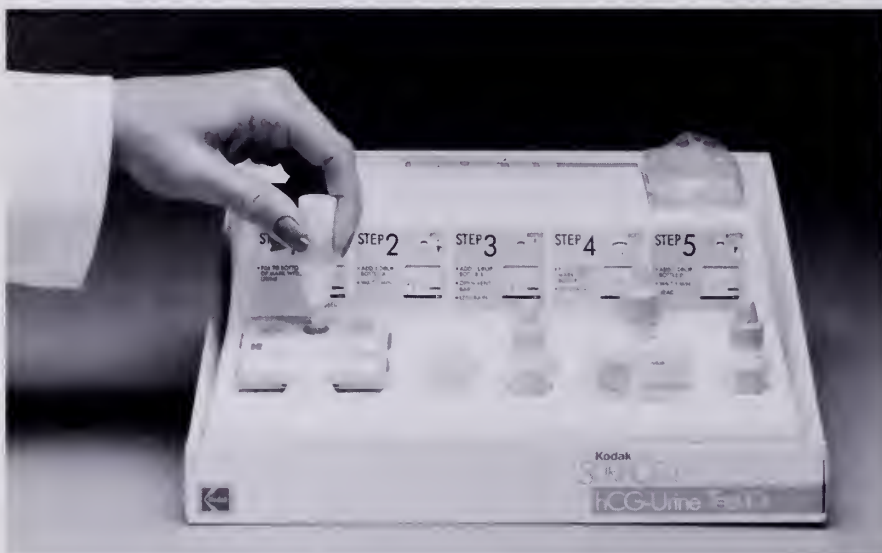
Of primary concern, they say, is *who* is responsible for the laboratory's quality control?

"Someone needs to run daily quality-control checks," says Somerson. "Will the physician do it, or will he or she act in a supervisory position — not actually running the checks, but ensuring that someone does?"

"Much of the proficiency of your lab *will* depend on who you hire to run it," agrees Richardson. Both men believe that a physician's optimum choice of personnel for quality-control supervision is an American College of Clinical Pathologist (ACCP)-accredited medical technologist.

"That's their profession," explains Somerson. "That's what they are trained to do. They really have the best qualifications for the job."

It's tempting to delegate responsibility to an office staff member, admits Richardson. Equipment has improved over the years, and just about anyone can



The hCG-urine test for pregnancy (above) provides physicians with results in two minutes.

run the controls.

"They look simple, they're advertised as simple, but the person has to be familiar with the procedure being done and be well-versed in troubleshooting because if the results of the test or the quality-control check isn't right, he or she needs to know what to do."

"Of course, the better help you have, the better things will go," adds Somerson.

And that includes guiding you through the complex issue of quality control.

As Somerson has already noted, those daily instrument/assay checks can help you easily identify any problems that may skew your lab's results, but there are *other* methods you should be using to ensure accuracy as well.

For example, proficiency testing — where an outside lab or agency is contracted to monitor your lab's performance and measure it against the performance of other office labs using identical procedures — is the most common method used. With this method, the outside lab will send you a control to test, then evaluate your lab's result when you send it back.

External Comparative Evaluation

for Laboratories (EXCEL), the program offered by the College of American Pathologists, has been specifically designed to monitor physician office laboratories, but it is only one of many similar programs that are offered to physicians.

That's where your qualified personnel can step in to guide you to the program that best suits the needs of your particular laboratory. They can also steer you to the right equipment if you have not yet purchased any. If you have, then at least let them purchase supplies for the lab on a regular basis, say both men — as setting up and maintaining an inventory can be tricky.

"Stockpiling reagents, for example, is not a good idea, because ingredients expire," says Richardson. Therefore, special care must be taken not to order too far ahead.

That's not to say, however, that undersupplying your lab is a good idea — in fact, that comes with its *own* set of problems, so both Richardson and Somerson suggest you let the expert handle this side of your laboratory setup.

Still another way of ensuring

quality in your laboratory is to draw up a "maintenance of standards," similar to those drawn up for independent laboratories — a point-by-point guide of what checks to run, what tests to make, and so on. This guide will allow you and your personnel to maintain the same accurate standards, day to day, month to month, year to year. Besides, that guideline or procedural manual will have to be produced at the annual inspection, currently required of all Medicare laboratories.

"What we often find in an inspection is that the guidelines have been set up all right, but they're not being followed," says Somerson.

So make sure that you not only *have* a maintenance of standards manual — but that you and your staff are familiar with it AND USE IT.

What else will the inspectors be looking for?

Each inspector is furnished by Medicare with a checklist of items, explains Somerson — but you can expect to be reviewed on the following:

- are certain standards (expected at all laboratories) being met?
- are you involved in proficiency testing?
- are safety-preventive measures taken with your equipment?
- do you have a procedure manual, and are you following it?

The idea of lab inspection is not to evoke a crime-and-punishment scenario, Somerson and Richardson insist, but instead to help laboratories reach peak efficiency.

"There are very few 'bad labs,'" says Somerson. "There are, however, laboratories in need of help, and that's why we're there — to help them out."

It's the inspector's job, he says, to help the lab correct its problems

and improve — not to shut it down. Of course, Medicare does have mechanisms in place to close down laboratories — if it finds it necessary to do so.

“But the only time they will go after a laboratory is if they feel it is life-threatening,” explains Somerson. Obviously, such shutdowns rarely occur, but even if one *is* ordered, the lab does have some legal recourse available to it. It’s not a cut-and-dry procedure, he continues.

Still, the purpose behind inspections is to improve the quality of the lab being inspected and to help the physician — as well as his or her patients — gain more confidence in test results.

“Most consider us a help rather than a hindrance,” adds Somerson. “Most laboratories, whether they are in physicians’ offices or working independently, are striving to do a professional job. They’re concerned about turning out quality work. The plus factor we offer is distance. We’re not so close to the problems that we can’t see them.”

“When we survey labs,” adds Richardson, “we’re not looking for problems. We’re there to provide assistance, and to help physicians have more confidence in the results their lab is turning out.”

Of course, such assurances do not come cheap.

“When doctors make their initial calculations on whether or not it would pay them to put a lab in their practice, they shouldn’t forget to factor in quality assurance costs,” says Richardson. “Their costs may be lower if they don’t add in all those quality-controls, like proficiency testing, but as far as patient care is concerned, it will cost them in the long run.”

So what does quality assurance cost? That depends on a number of things. Will you hire a medical technologist or train your office staff to run the lab? What type of

equipment will you buy? Who will you contract to perform your proficiency testing?

Quality never comes cheap — but on the other hand, the price one pays for quality personnel, equipment and services is not cost-prohibitive either.

“You *can* have an accurate lab and still make a profit,” says Somerson.

But it will take some planning.

“If you know what your volume is, you can figure how high your costs will be,” Richardson adds. If your volume doesn’t promise to be much — you may want to rethink your need for an in-office laboratory — or, at least, what tests you will offer patients.

“You don’t *have* to offer a wide variety of tests,” says Richardson. In fact, it makes sense to send all but the high-volume routine tests out to other labs — and most physicians, he says, should not try to identify microorganisms or test for AIDS in their offices.

The former, he explains, requires

specialized training and equipment; the latter is, quite simply, dangerous.

“If the AIDS test comes back positive, you’re going to retest then send it out for confirmation anyway, so why do it?” he asks — especially when blood banks are mandated to do AIDS testing, and are better able to handle all the safety precautions that must be taken.

“It’s definitely not a program a doctor is going to want to start up with,” he sums up.

So what tests *do* lend themselves to in-office work? Hematology, coagulation, urinalysis, chemistry, whole blood glucose, serum hCG, direct bilirubin and gamma glutamyl transferase are a few of the more obvious ones. Again, however, the final decision of which tests to set up in your office will depend on your practice and patients.

The pending legislation that threatens to regulate physician office laboratories (or at least



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those providing more than 5,000 tests a year) is still 16 months away, and the AMA will do what it can, in the meantime, to convince the government that regulation is not necessary — that there are mechanisms in place already that will assure the quality of in-office laboratory testing.

In fact, at its 1988 Annual Meeting, AMA's House of Delegates issued a policy statement supporting the development of national quality assurance standards, based on such factors as proficiency testing, quality control and continuing education. The statement also supported the accreditation program of the Commission on Office Laboratory Assessment (COLA), which is in the process of developing national

quality assurance standards with the College of American Pathologists, the American Society of Internal Medicine and the American Academy of Family Practice. The COLA program is now in the implementation stage, which makes the upcoming regulation of physician office labs superfluous and therefore unnecessary, says the AMA.

Further, the proposed regulation could limit the physician's ability to provide clinical laboratory services which, in turn, could reduce patient access to necessary and timely clinical laboratory services, the AMA continues.

No one, however, believes that office labs should be run without accountability — without knowing and assuring that test results will

be as true and accurate as possible.

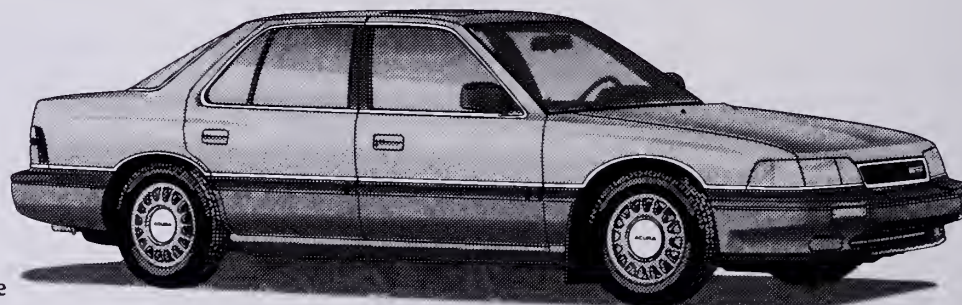
"Physicians and patients both put such blind faith in the results produced by a lab. They assume that the test has been carefully run and checked, that quality has been maintained throughout, and that the results the lab produces are accurate," says Richardson.

To assure that, quality control — whether it's regulated or comes through other channels — is necessary, Richardson insists, adding: "In the long run, it will help physicians gain better quality care for their patients."

Karen S. Edwards is the Executive Editor of OHIO Medicine.

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Telephone Contact With the Patient

The role of a physician's office staff cannot be underestimated as a tool in maintaining good doctor-patient relationships. Often, the initial contact between doctor and patient is made through the assistant or office staff. The success of this contact either can foster the patient's satisfaction . . . or add to a growing feeling of dissatisfaction which may have been building in the patient over time.

Channelling Telephone Calls

The doctor needs to provide assistants with a listing that outlines the kind of telephone calls that can be channeled *to whom* and *when*. Examples:

- Calls to be sent through immediately.

These include emergencies (calling for two procedures: when you are in the office, and the other for times when you are out); calls concerning important test results; calls from other doctors and hospital personnel.

- Calls to be returned when you are free.

These can include nonemergencies, routine test results and routine prescription refills. Also included in this category are house-call requests and phone calls concerning nonurgent patient reports of unsatisfactory progress.

- Calls that assistants can handle.

Examples include: appointments;

calls regarding insurance claims, fees or billing statements; and reports of satisfactory patient progress.

Avoid Overuse of the Hold Button

A patient should not be put on hold before having the opportunity to state the reason for calling. The consequences of doing this can be more serious in the case of emergency calls.

An assistant who does not use the hold button, however, presents a different problem. If the phone is simply put down on the desk with the line open, the caller may hear everything, including conversations among the office staff.

Recognize the Importance of Listening

Phone calls from patients shouldn't become a battle of wills. The patient expects the assistant to listen to a description of the problem without interruption. It's further expected that the importance of the problem will be quickly assessed and relayed accurately to the doctor.

(You may want to ask your answering service to identify itself as a service. Patients resent explaining a situation to someone they assume to be your assistant, only to discover that they have been talking to an answering service.)

Each message should be detailed

and precise, and a telephone log must be maintained. Some offices choose to develop their own message/response forms; others may select from commercially prepared forms that document phone call information for patient files.

Knowing When to Back Down

Attempts at efficient scheduling shouldn't be allowed to alienate patients. Asking the nature of the problem may elicit an indirect answer or none at all. Some patients are too embarrassed to discuss a condition with anyone except the physician, and an assistant who persists will likely get an agitated response. The assistant needs to learn to back down before the patient loses his temper or hangs up.

. . . And Knowing When Not to Answer

An assistant may unknowingly offer information that can be used against you — all in an attempt to be helpful. There have been reports of attorneys (for patients contemplating a malpractice lawsuit) calling the doctor's office and posing as a family member, a hospital records clerk or even another physician. Information such as dates of patient visits or hospitalizations, the nature and extent of services rendered, and the names of the physician(s) handling

continued on page 895



A HEALTHY NEW SIGN IN WEST VIRGINIA

The road to recovery runs both ways. Proof of that is the new Women and Children's Hospital of West Virginia. A healthy new sign for us all.

Women and Children's is a specialized facility of Charleston Area Medical Center devoted exclusively to the physical and emotional needs of women and children. And a new referral source for you, the doctors who care for them. A source for tertiary and specialized care for women and children, the 120-bed hospital offers many types of care found nowhere else in West Virginia.

State-of-the-art technology combines with specialists and sub-specialists in fields such as:

- Infertility • Perinatology • Neonatology
- Pediatric cardiology, hematology, oncology, nephrology

We value your referrals for consultation or tertiary services. And we invite you to take a tour of our hospital. To arrange a tour, or for more information, call our administrator, Shirley Perry at (304) 347-9233.

**WOMEN
AND
CHILDREN'S
HOSPITAL**

Division of Charleston Area Medical Center

OSMA FINANCIAL STATEMENT

OHIO STATE MEDICAL ASSOCIATION

Report on Examination of Financial Statements for the Years Ended December 31, 1987 and 1986

REPORT OF INDEPENDENT ACCOUNTANTS

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheets of Ohio State Medical Association at December 31, 1987 and 1986 and the related statements of operations, changes in net worth, and cash flows for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the

circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of Ohio State Medical Association at December 31, 1987 and 1986 and the results of its operations and its cash flows for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Columbus, Ohio
April 29, 1988

OHIO STATE MEDICAL ASSOCIATION BALANCE SHEET, December 31, 1987 and 1986

ASSETS	1987	1986
Current assets:		
Undesignated cash and cash equivalents	\$2,752,751	\$2,680,512
Accounts receivable	126,661	76,571
Accounts receivable, PICO		48,527
Accrued interest receivable	39,717	43,296
Prepaid expenses	39,422	38,435
Total current assets	<u>2,958,551</u>	<u>2,887,341</u>
Other assets:		
Marketable securities (Notes 1, 2 and 3)	1,242,127	983,644
General Trust Fund, at approximate market	55,819	47,272
Notes receivable (Note 5)	131,250	154,759
Investments:		
Physicians Insurance Company of Ohio (PICO), at cost (Notes 4, 7 and 8)	100,000	100,000
622 South High Street, Inc. (Notes 5 and 12)	21,497	22,302
Real estate (building — \$2,090,000; equipment — \$260,000; net of accumulated depreciation of \$430,375 in 1987 and \$352,125 in 1986) (Note 8 and 12)	1,919,625	1,997,875
IONA, Inc., at cost	25,000	25,000
	<u>3,495,318</u>	<u>3,330,852</u>
Property and equipment, at cost (Notes 1, 7 and 8):		
Building	572,481	572,481
Data processing equipment	215,229	195,323
Furniture, fixtures and equipment	115,610	115,610
Property under capital leases	33,266	
	936,586	883,414
Less accumulated depreciation and amortization	(445,683)	(408,495)
	490,903	474,919
Land	448,628	448,628
	939,531	923,547
	<u>\$7,393,400</u>	<u>\$7,141,740</u>

The accompanying notes are an integral part of the financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1. Accounting Policies:

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

a. Marketable Securities:

Marketable securities consist of United States Treasury notes and Federal Home Loan Bank bonds and are recorded at the lower of aggregate cost or market.

b. Depreciation:

The Association recognizes depreciation and amortization on the straight-line method in amounts adequate to amortize costs over the estimated useful lives of the assets as follows:

Building and improvements 10-40 years
Data processing equipment 5 years
Furniture, fixtures and equipment 10 years
Property under capital leases is amortized over the estimated useful life of the asset or the lease term, if shorter, using the straight-line method.

Depreciation and amortization charged to operations were \$115,438 in 1987 and \$141,389 in 1986, including depreciation on a building leased to PICO (Note 8). Disposals of fixed assets are accounted for as reductions to cost and accumulated depreciation. Any resulting gain or loss is credited or charged to other income.

c. Deferred Membership Dues:

Income from annual membership dues is recognized in the calendar year to which the dues apply.

d. Exemption — Federal Taxes on Income:

The Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.

e. Cash Equivalents:

For purposes of reporting cash flows, the Company considers all highly liquid debt instruments purchased with a maturity of three months or less to be cash equivalents.

f. Reclassifications:

Certain amounts in the 1986 financial statements have been reclassified to conform to the current year presentation.

2. Marketable Securities:

At December 31, 1987 and 1986, aggregate cost and market value of noncurrent marketable securities are as follows:

	1987	1986
Aggregate cost	\$1,285,730	\$ 983,644
Aggregate market value	1,242,127	1,017,835
Valuation allowance	43,603	

At December 31, 1987, there were \$43,603 of unrealized losses and no realized gains on marketable securities. At December 31, 1986, there were \$38,979 of unrealized gains and \$3,058 of unrealized losses on marketable securities. There were no sales of marketable securities during 1987.

At December 31, 1987 and 1986, \$906,702 and \$761,681, respectively, of these securities have been restricted for designated purposes (see Note 3).

3. Funds Restricted for Designated Purposes:

As of December 31, 1987 and 1986, the Council of the Ohio State Medical Association had authorized funds to be restricted for designated purposes. The funds represent noncurrent mar-

ketable securities that have been designated for the following purposes as of December 31:

	1987	1986
Capital Asset Improvements and Replacement	\$281,394	\$268,233
Data Processing Improvements and Replacement	401,094	380,132
Malpractice Research	9,944	9,423
Staff Development	109,621	103,893
Legislative Action	104,649	
	<u>\$906,702</u>	<u>\$761,681</u>

4. Physicians Insurance Company of Ohio and Subsidiaries:

The Association owns 100% of the Class B common stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each class of stock has equal rights on a per share basis to participate in dividends and other types of distributions. Each Class A share is entitled to one vote, and each Class B share is entitled to 100 votes.

By virtue of its ownership of 100% of the outstanding Class B shares (36,000 shares), the Association is entitled to 3,600,000 votes. At December 31, 1987, the Class A shareholders owned 3,043,542 shares of Class A stock. Accordingly, at December 31, 1987, the Association was entitled to exercise 54.19% of the voting power of PICO. If the total authorized Class A shares (8,000,000) and Class B shares (66,668) were to be sold, the Class B shareholders would hold approximately 45% of the voting control over PICO.

The Association has recorded its investment in PICO at cost instead of under the equity method since, although owning a controlling interest in PICO, the Association does not share significantly in PICO's earnings.

PICO is limited to selling medical liability insurance only to members of the Association. PICO wishes to encourage medical students to join the Association, hopefully leading to future insurance business for PICO. As a result, the Association and PICO entered into an agreement whereby PICO agreed to reimburse the Association for direct and indirect costs of promoting organized medicine, including the promotion and servicing of new student and resident memberships in the Association. Total reimbursements for the national, state and county medical society membership dues of medical students and residents, including reimbursement for costs incurred in promoting and servicing the student and resident memberships, were \$451,911 in 1987 and \$448,527 in 1986. OSMA's portion of such reimbursements was \$216,760 and \$217,500 in 1987 and 1986, respectively, and is included in membership dues income in the statement of operations and undesignated net worth.

In connection with a group professional liability insurance plan, OSMA earns interest income on premium payments from its member physicians.

5. Investment in 622 South High Street, Inc.:

During 1981, OSMA formed a corporation known as 622 South High Street, Inc. (622), having as its main purpose the ownership of a single parcel of property at 622 South High Street, Columbus, Ohio.

OSMA accounts for the investment using the equity method, and the investment account reflects the following activity for the years ended December 31:

	1987	1986
Investment in 622,		
beginning of year	\$22,302	\$23,459
Net loss	(805)	(1,157)
Investment in 622,		
end of year	<u>\$21,497</u>	<u>\$22,302</u>

In addition to its investment, the Association has a note receivable from 622 which had a book value of \$60,842 at December 31, 1987 and 1986.

The balance sheet of 622 South High Street, Inc. is immaterial to the balance sheet of the Association.

6. Physicians Administrative Corporation of Ohio:

During 1982, OSMA formed a corporation known as Physicians Administrative Corporation of Ohio (PACO). Through December 31, 1985, OSMA made investments in and advances to PACO totaling \$718,728, all of which have been recognized as losses either through PACO's operating loss or through reserves against outstanding advances (notes receivable). PACO's operating activities were terminated on December 31, 1985, and PACO's only activities since termination were related to the disposition of certain assets and settlement of remaining obligations. OSMA did not make any further investments in or advances to PACO during 1986 and 1987.

On November 17, 1987, PACO was dissolved by their Board of Trustees and notice sent to the Secretary of State. Activity during 1987 consisted solely of payment of tax liabilities which had been accrued at December 31, 1986.

7. Long-Term Obligations:

Long-term obligations at December 31, 1987 and 1986 consisted of the following:

	1987	1986
14.5% mortgage loan payable in annual installments of \$361,472, including interest, beginning December 1, 1983, collateralized by the assignment of rents and security deposits from PICO (see Note 8) and due December 1, 1989.	\$2,374,462	\$2,389,462
8% mortgage loan payable in monthly installments of \$500, including interest computed semiannually, collateralized by land and building. OSMA has the right of prepayment.	68,728	69,209
	2,443,190	2,458,671
Less current portion	17,696	15,481
	<u>\$2,425,494</u>	<u>\$2,443,190</u>

Required payments of long-term obligations, exclusive of the 14.5% mortgage loan which was repaid in March 1988 (see Note 12), are as follows:

1988	\$ 521
1989	564
1990	611
1991	661
1992	716
Later years	65,655
	<u>\$68,728</u>

8. Leases:

The Association leased office facilities and equipment with a net book value of \$1,919,625 to PICO, a related party (see Note 4), under terms of an operating lease. The office facility lease had a scheduled expiration date of January 15, 1995, with monthly rent of \$26,875. The equipment lease had a scheduled expiration date of January 15, 1993, with monthly rent of \$3,600. PICO exercised its option to purchase the office facility and equipment effective in March 1988 (see Note 12). The Association leased the land on which the above facility is located from PICO under terms of an operating lease. PICO has also exercised its option to terminate this lease effective in March 1988.

The following is a summary of the activity related to the above transactions for the years ended December 31:

	1987	1986
Rental income	\$365,700	\$365,700
Interest income	10,558	10,810
	<u>376,258</u>	<u>376,510</u>
Expenses:		
Rent	4,800	4,800
Interest (Note 7)	346,472	348,371
Depreciation	78,250	78,250
	<u>429,522</u>	<u>431,421</u>
Net loss	<u>\$ 53,264</u>	<u>\$ 54,911</u>

Additionally, OSMA leases automobiles and certain office equipment for terms of up to five years. Minimum annual rental commitments under noncancelable leases as of December 31, 1987 are as follows:

	Capital Leases	Operating Leases
1988	\$16,820	\$ 91,489
1989	15,527	77,473
1990	11,342	55,728
1991		3,134
Total minimum lease payments	43,689	<u>\$227,824</u>
Less amount representing interest	11,781	
Present value of minimum lease payments	<u>\$31,908</u>	

During 1987, the Association leased property under capital leases which has been valued at \$33,266 in accordance with Statement of Financial Accounting Standards No. 13. At December 31, 1987, accumulated amortization on property under capital leases was \$2,740.

Rental expense for 1987 and 1986 was \$108,633 and \$127,318, respectively.

LIABILITIES AND NET WORTH

	1987	1986
Current liabilities:		
Accounts payable and accrued expenses	\$ 165,711	\$ 255,61
Accounts payable, PICO (Note 4)		5,47
Current portion, term debt (Note 7)	17,696	15,48
Current portion, capital lease obligations (Note 8)	10,095	
Dues collected in advance for related societies in the federation	799,989	928,22
Accrued pension expense	104,531	124,82
Total current liabilities	<u>1,098,022</u>	<u>1,329,63</u>
Long-term obligations:		
Term debt (Note 7)	2,425,494	2,443,19
Capital lease obligations (Note 8)	21,813	
	<u>2,447,307</u>	<u>2,443,19</u>
Deferred membership dues (Note 1)	837,285	976,01
Net worth (Note 3):		
Designated funds	906,702	761,68
Undesignated funds	2,147,687	1,631,22
Net unrealized loss on noncurrent marketable securities	(43,603)	
Total net worth	<u>3,010,786</u>	<u>2,392,90</u>
	<u>\$7,393,400</u>	<u>\$7,141,74</u>

The accompanying notes are an integral part of the financial statements.

STATEMENT OF OPERATIONS for the years ended December 31, 1987 and 1986

	1987	1986
Income:		
Membership dues (Notes 1, 4 and 11)	\$3,666,523	\$3,330,67
Exhibit fees	4,800	7,20
Annual meeting	45,510	17,02
Fees for collection of AMA dues	17,005	8,82
CME accreditation and courses	30,679	9,53
Ohio State Medical Journal (Note 11)	228,642	174,35
Interest	360,707	342,01
General trust income (expense), net	8,547	(18,53)
Rental income	3,800	3,90
Services to specialty societies	68,237	82,46
Legislative policy fund contributions	153,414	
Other, net	134,908	108,82
	<u>4,722,772</u>	<u>4,066,28</u>
Departmental operating expenses:		
Administration	581,481	647,71
Education, specialty societies and meeting management	743,210	573,22
Health education	164,684	127,97
Fiscal and membership	540,722	503,88
Government relations	176,457	265,37
Communications	769,486	722,32
Development and member services	272,732	323,50
State legislation	495,378	312,10
Legal services	263,072	214,02
	<u>4,007,222</u>	<u>3,690,14</u>
Income from operations before loss from lease to related party and equity in loss of subsidiary	715,550	376,14
Loss from lease to PICO (Note 8)	(53,264)	(54,91)
Equity in loss of 622 South High Street, Inc. (Note 5)	(805)	(1,15)
Net income	<u>\$ 661,481</u>	<u>\$ 320,07</u>

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CHANGES IN NET WORTH
for the years ended December 31, 1987 and 1986

	Total	Designated Funds	Undesignated Funds	Net Unrealized Loss On Noncurrent Marketable Securities
Balances, January 1, 1986	\$2,072,834	\$651,392	\$1,421,442	
Net income	320,074		320,074	
Transfer to designated funds		110,289	(110,289)	
Balances, December 31, 1986	2,392,908	761,681	1,631,227	
Net income	661,481		661,481	
Additions to designated funds		198,736	(198,736)	
Expenditures from designated funds		(53,715)	53,715	
Unrealized loss on noncurrent marketable securities	(43,603)			\$(43,603)
Balances, December 31, 1987	<u>\$3,010,786</u>	<u>\$906,702</u>	<u>\$2,147,687</u>	<u>\$(43,603)</u>

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CASH FLOWS
for the years ended December 31, 1987 and 1986

	1987	1986
Cash flows from operating activities:		
Net income	\$ 661,481	\$ 320,074
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	115,438	141,389
Equity in loss of subsidiary	805	1,157
	<u>777,724</u>	<u>462,620</u>
Changes in assets and liabilities:		
Increase in accounts receivable	(1,563)	(41,573)
(Increase) decrease in accrued interest receivable	3,579	(16,823)
(Increase) decrease in prepaid expenses	(987)	9,068
Decrease in accounts payable and accrued expenses	(95,384)	(33,050)
Increase (decrease) in dues collected in advance for related societies in the federation.	(128,242)	267,149
Increase (decrease) in accrued pension expense	(20,292)	3,301
Increase (decrease) in deferred income	(138,727)	280,780
Net cash provided by operating activities	<u>396,108</u>	<u>931,472</u>
Cash flows from financing activities:		
Repayment of term debt and lease obligations	(16,839)	(13,543)
Capital lease obligations	33,266	
Cash flows from financing activities	<u>16,427</u>	<u>(13,543)</u>
Cash flows from investing activities:		
(Increase) decrease in noncurrent marketable securities	(302,086)	273,134
(Increase) decrease in General Trust Fund	(8,547)	18,538
(Increase) decrease in notes receivable	23,509	(18,552)
Additions to property and equipment, net	(53,172)	(13,731)
Cash flows from investing activities	<u>(340,296)</u>	<u>259,389</u>
Increase in undesignated cash and cash equivalents	72,239	1,177,318
Undesignated cash and cash equivalents:		
Beginning of year	<u>2,680,512</u>	<u>1,503,194</u>
End of year	<u>\$2,752,751</u>	<u>\$2,680,512</u>
Supplemental disclosures of cash flow information:		
Cash paid during the year for:		
Interest	\$ 7,683	\$ 5,557
Supplemental schedule of noncash activities:		
Capital lease obligations of \$33,266 were incurred for new equipment in 1987		

The accompanying notes are an integral part of the financial statements.

DEPARTMENTAL OPERATING EXPENSES
for the years ended December 31, 1987 and 1986

	Adminis- tration	Education and Meeting Management	Specialty Societies	Health Education	Fiscal and Membership	Government Relations	Communi- cations	Development and Member Services
Salaries and benefits	\$231,283	\$181,484	\$130,514	\$ 98,076	\$318,170	\$118,956	\$209,314	\$116,836
Staff development	38,919				516			
Pension costs	14,414	12,287	19,674	7,027	25,296	12,648	16,864	9,837
Staff expenses	30,055	8,653	8,617	6,328	8,503	4,369	16,722	3,299
President expense and honorarium	18,376							
President-Elect expense and honorarium	7,341							
Past-President honorarium	4,000							
Secretary- Treasurer honorarium	5,000							
Council expense	82,479							
AMA delegate and alternates' expense								98,017
Committees expense		47,011		16,716	68,669	2,347	296	4,023
Annual meeting		219,689						
Building expenses	14,932	12,778	4,262	3,776	12,411	4,024	17,647	6,136
Depreciation	5,184	4,990	1,665	1,474	4,847	1,571	8,204	2,397
Car lease expense	30,149	4,223	2,400	4,383	3,581	4,751	3,281	3,600
Councilor district conferences	6,067							
Data processing	1,755	13,922	1,821	169	602	2,280	12,312	768
Equipment rental	10,282	8,066		2,931	9,979	3,038	14,427	4,725
Emergency fund	17,136	163	140	28	12,133	843	2,154	3,389
Doubtful accounts					4,057			
Insurance and bonding	6,842	3,996	1,565	1,685	3,942	1,863	5,333	2,305
Interest expense	860	827	276	244	804	261	2,878	397
Legal expense	1,652							
Legislative action								
Library	2,447	1,005	24	94	672	1,982	1,768	197
Meeting expense	1,358			8,089				
<i>OSMAgram</i>							54,390	
<i>Journal</i> printing and postage							222,606	
<i>Journal</i> advertising							5,411	
Postage	6,705	2,988	1,806	2,263	18,980	3,376	13,845	2,080
Professional relations	1,394	1,448	433	384	1,261	559	1,793	624
Public relations							115,304	
Supplies, miscellaneous	1,361	1,310	437	387	1,272	412	1,809	642
Supplies, office	7,850	6,381	1,453	1,109	12,591	1,310	10,004	1,775
Taxes, payroll and other	24,017	16,602	8,023	6,784	25,326	8,950	17,535	7,236
Telephone and telegraph	9,623	9,263	3,014	2,737	7,110	2,917	15,589	4,449
Totals	<u>\$581,481</u>	<u>\$557,086</u>	<u>\$186,124</u>	<u>\$164,684</u>	<u>\$540,722</u>	<u>\$176,457</u>	<u>\$769,486</u>	<u>\$272,732</u>

State Legislation	Legal Services	1987 Total	1986 Total
\$245,702	\$127,009	\$1,777,344	\$1,608,425
		39,435	100,000
9,837	12,648	140,532	109,868
72,110	15,867	174,523	154,263
		18,376	19,080
		7,341	7,775
		4,000	4,000
		5,000	4,000
		82,479	61,414
		98,017	109,143
7,628	19,667	166,357	126,545
		219,689	177,513
11,363	6,192	93,521	97,017
4,438	2,418	37,188	63,138
7,835	2,360	66,563	54,347
		6,067	5,851
7,892	1,654	43,175	31,027
8,520	5,202	67,170	73,728
3,785	974	40,745	55,529
		4,057	1,930
4,532	2,113	34,176	26,862
736	400	7,683	5,556
	39,974	41,626	62,127
52,132		52,132	
3,603	3,455	15,247	10,475
		9,447	18,578
		54,390	55,688
		222,606	212,797
		5,411	385
3,529	2,798	58,370	43,607
1,155	629	9,680	6,010
		115,304	128,841
1,165	634	9,429	9,581
22,696	4,234	69,403	63,592
18,483	10,355	143,311	114,284
8,237	4,489	67,428	67,168
<u>\$495,378</u>	<u>\$263,072</u>	<u>\$4,007,222</u>	<u>\$3,690,144</u>

9. Pension Plan:

The Association maintains a trustee noncontributory defined benefit pension plan for its eligible employees. The actuarial cost method used in determining the valuation of funding is the entry-age-normal with frozen-initial-liability method. The trustee of the plan is American Physicians Life Insurance Company, a subsidiary of PICO and a related party to OSMA.

The total cost of the plan charged to operations in 1987 and 1986 was \$140,531 and \$109,720, respectively, which includes amortization of past service costs over approximately a 30-year period.

A comparison of the accumulated benefits and net assets available for benefits for the plan years beginning December 31, is as follows:

	1986	1985
Actuarial present value of accumulated plan benefits:		
Vested	\$1,168,448	\$1,019,691
Nonvested	92,843	81,884
Total	<u>\$1,261,291</u>	<u>\$1,101,575</u>
Market value of plan assets available for benefits	<u>\$1,617,011</u>	<u>\$1,465,747</u>

The assumed investment rate of return used in determining the actuarial present value of accumulated plan benefits was 8.0%.

10. Postretirement Benefits:

In addition to providing pension benefits, the Association provides certain health-care benefits for retired employees. All of the Association's employees may become eligible for those benefits if they reach normal retirement age while still working for the Association. The Association recognizes the cost of providing those benefits by expensing the insurance premiums which were \$16,258 and \$12,433 for 1987 and 1986, respectively.

11. Ohio State Medical Journal:

The income and expenses applicable to the operations of *Ohio State Medical Journal*, for the year ended December 31, 1987, are:

Income:

Advertising (net of commissions and cash discounts of \$55,461)	\$228,111
Outside subscriptions and other income	531
	<u>228,642</u>

Expenses:

Salaries, pension costs, payroll taxes and other employee benefits	125,968
Printing, postage, stationery, supplies, illustrations, engravings and consulting services	228,017
Building expenses, depreciation and other	72,995
	<u>426,980</u>

Excess of expenses over income,
Ohio State Medical Journal

\$(198,338)

To the extent that the *Journal* has excess expenses such expenses are subsidized by membership dues.

12. Subsequent Events:

In March 1988, PICO exercised its option to purchase office facilities and equipment with a net book value of approximately \$1,900,000 from the Association for cash of \$2,479,919 resulting in a gain of approximately \$580,000 (see Notes 4 and 8). The Association used the proceeds to retire the 14.5% mortgage loan (see Note 7).

The Association has entered into an agreement to sell its land and office building, including the 622 South High Street, Inc. property (see Note 5), for cash of \$1,300,000 resulting in a gain of approximately \$375,000.

The Association has entered into a seven-year lease agreement for new office facilities commencing August 1, 1988. Under the terms of the lease agreement the Association must make monthly lease payments of \$24,052 plus a proportionate share of building operating costs. In addition to the basic lease agreement, the Association has entered into an agreement that allows it to share in operating cash

flow from the building being leased and to acquire an equity interest in the building.

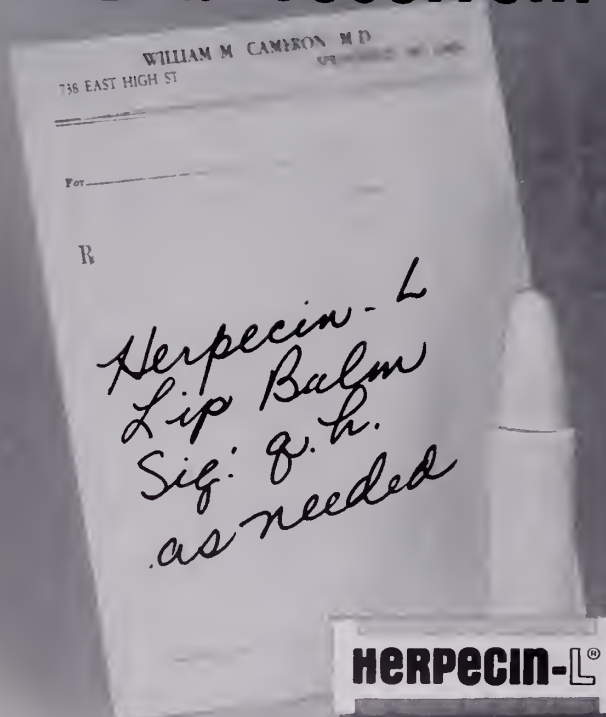
SUPPLEMENTAL FINANCIAL DATA

Our report on our examinations of the financial statements of Ohio State Medical Association as of December 31, 1987 and 1986, and for the years then ended, appears on page 1. These examinations were made primarily for the purpose of rendering an opinion on the basic financial statements, taken as a whole, shown on pages 2 to 16 of this report. The supplemental financial data included in this report on pages 18 and 19 is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the examinations of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

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OBITUARIES

HELEN CASH, MD, Cleveland; Case Western Reserve University School of Medicine, 1951; age 69; died May 24, 1988; member OSMA and AMA.

BENJAMIN CHAVINSON, MD, Cleveland; University of Louisville School of Medicine, Louisville, KY, 1928; age 84; died May 26, 1988; member OSMA and AMA.

WILLIAM EDWARD CREW, MD, Cleveland; Howard University College of Medicine, Washington, DC, 1944; age 76; died May 4, 1988; member OSMA and AMA.

CRAWFORD L. FELKER, MD, Toledo; Vanderbilt University School of Medicine, Nashville, TN, 1934; age 80; died April 24, 1988; member OSMA and AMA.

JOHN J. EVANS, MD, Cleveland; Loyola University Stritch School of Medicine, Maywood, IL, 1936; age 80; died June 3, 1988; member OSMA and AMA.

FRANCIS J. FLANAGAN, MD, Dublin, GA; Medical College of Wisconsin, Milwaukee, WI, 1943; age 68; died April 12, 1988; member OSMA and AMA.

CHARLES R. FORRESTER, MD, Toledo; Loyola University Stritch School of Medicine, Maywood, IL, 1939; age 76; died May 2, 1988; member OSMA and AMA.

ANTHONY GARLISI, MD, Tiffin; Facolta di Medicinal e Chirurgia dell' Universita di Roma, Roma, Italy, 1943; age 72; died May 21, 1988; member OSMA.

REGIS F. GOLUBSKI, MD, Cleveland; Case Western Reserve University School of Medicine, 1938; age 75; died May 20, 1988; member OSMA and AMA.

VINCENT GRIGGS, Cincinnati; University of Cincinnati College of Medicine, 1990; age 24; died May 5, 1988; member OSMA and AMA.

ORVILLE L. LAYMAN, MD, Franklin; Ohio State University College of Medicine, 1932; age 82; died May 18, 1988; member OSMA and AMA.

ELLIS W. LIST, JR., MD, Bristolville; Ohio State University College of Medicine, 1959; age 55; died March 21, 1988; member OSMA and AMA.

RUSSELL S. MCGINNIS, MD, Cleveland; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1921; age 92; died June 4, 1988; member OSMA and AMA.

JOHN R. MCKAY, MD, Hilton Head Island, SC; Case Western Reserve University School of Medicine, 1939; age 73; died May 2, 1988; member OSMA and AMA.

JACK W. MILLIS, MD, Houston, TX; University of Illinois at Chicago Health Sciences, Chicago, IL, 1940; age 74; died April 26, 1988; member OSMA and AMA.

WILLIAM E. MISHLER, MD, Northfield; St. Louis University School of Medicine, St. Louis, MO, 1932; age 82; died June 6, 1988; member OSMA and AMA.

ROBERT E. MOFFATT, MD, Mansfield; Medical College of Virginia Commonwealth University School of Medicine, Richmond, VA, 1943; age 70; died June 3, 1988; member OSMA and AMA.

GERALD SCHREIBER, MD, New Athens; Ohio State University College of Medicine, 1948; age 78; died May 12, 1988; member OSMA and AMA.

SIMON SPENDIARIAN, MD, Sandusky; Orvosi Fakultas Tudomanyegyetem, Debrecen, Hungary, 1944; age 69; died April 30, 1988; member OSMA and AMA.

BERNARD TAYLOR, MD, Youngstown; Middlesex University School of Medicine, Waltham, MA, 1940; age 71; died May 26, 1988; member OSMA and AMA.

CARL E. TETIRICK, SR., MD, Columbus; Ohio State University College of Medicine, 1945; age 67; died June 14, 1988; member OSMA and AMA.

ROBERT L. WRIGHT, MD, Sanford, NC; University of Maryland School of Medicine, Baltimore, MD, 1956; age 57; died May 15, 1988; member OSMA.

Loss Awareness... continued

the case all are items that could be used against you.

It is vital for the assistant to understand that no information of any kind is to be given to anyone but the patient — not even to a spouse.

Only one correct response to such requests can be given by an assistant: "I'm not at liberty to tell you that. If you like, I will be happy to take your name and telephone number, and talk to the doctor about your request when he's free."

Attention to the recommendations outlined above can help lessen your exposure to risk. When incorporated in the normal procedures of your office, they further will reflect good patient relations skills and your concern for prompt and attentive care. **OSMA**

Prepared by the subcommittee on Loss Awareness with the assistance of PICO staff and the Oregon State Medical Association.

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Health Problems of Health-Care Workers

Editor: Edward A. Emmett, MB; 654 pp., Vol. 2/No. 3, July-September, 1987, Occupational Medicine: State of the Art Reviews, published quarterly by Hanley & Belfus, Inc., Philadelphia, \$60/yr.

This review covers the health problems and health hazards of one of America's largest industries. The health services sector employs over 7 million workers who are exposed to biologic agents, chemical agents, physical agents, stress and injury. Excellent chapters by recognized experts in the fields of epidemiology, immunology and infectious diseases, environmental health engineering, behavioral sciences and health education, occupational medicine and public health are written for the various health-care professionals as well as hospital administrators and the Employee Health Service.

The subject of health hazards of health-care workers is covered thoroughly by qualified individuals in each field, from transmission of HIV infection to indoor air quality in health-care facilities. Each chapter addresses a specific hazard or related hazards and is written by different experts. As a result, writing styles differ, and some chapters are more technical than others. However, each chapter is well-referenced, giving the reader an opportunity to review all the pertinent writings on a particular topic.

This reader was particularly impressed with the realization that the Occupational Health and Safety Administration (OHSa) has

not as yet addressed the health hazards of such a large industry. One reference cites the National Safety Council as reporting that a hospital employee is 41 percent more likely than the average U.S. worker to need time off because of serious occupational injury or illness. As an occupational medicine specialist, I would review this statement with concern for the cost of time lost from the job to the industry, as well as the lack of controls for health and safety within this industry. Further, the Bureau of Labor Statistics stated that the reported injuries and illnesses were higher in the health service industry than in many other industries, including mining, manufacturing, transportation and construction. Although we think of the health services sector as traditional medical care, more than 50 percent of the workers are employed in the trades. These include machinists, welders, electricians, maintenance workers, security guards, cooks, dietary personnel, housekeeping and the like who suffer the hazards, injuries and illnesses common to these trades.

Hospital and facility administrators, employee health services, and personnel officers would do well to review this timely publication. Particular attention

given to the chapter dedicated to the organization and conduct of a hospital occupational service would serve them well in prevention of lost time and productivity.

Physicians who have the responsibility for employee health will find many helpful chapters and practical guides for prevention of health problems. The chapters devoted to prevention of AIDS, hepatitis, teratogenic viral infections and control of infectious agents are well-written and clearly define the basic elements of a safety program. Inservice training programs would do well to include these topics on a periodic basis.

The chapters dealing with chemical dependency in health-care professionals and with the sources of stress are chapters which have personal worth to every nurse, physician, pharmacist, etc., as well as to those who are responsible for the health of these workers. The structure and the nature of our contemporary health-care delivery system is such that many stresses are imbedded in the occupations themselves. The resources of each worker must be considered when analyzing the extent and nature of demands and opportunities for control at work. — V.K. Yates, MD, Cleveland, *Occupational Medicine*.

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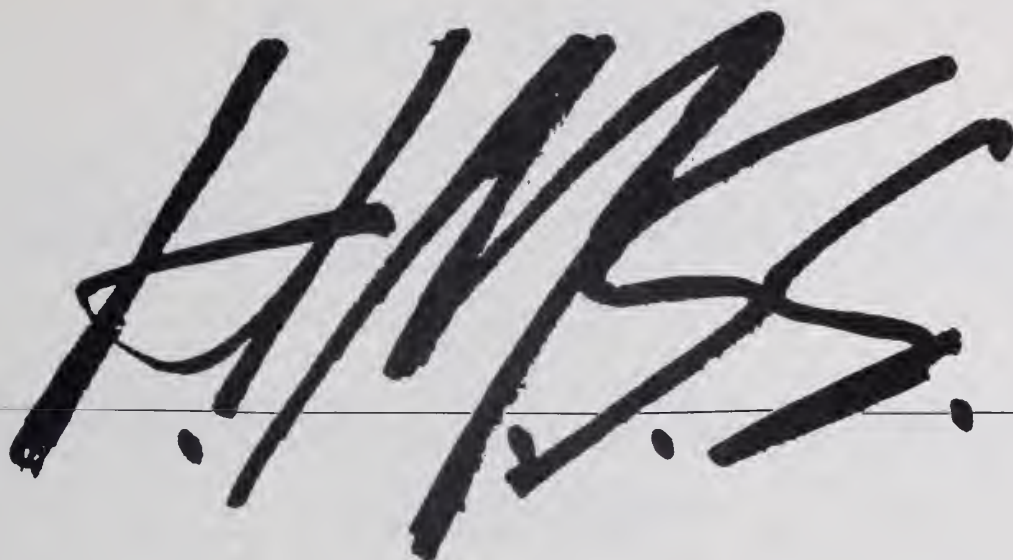
As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

We're encouraging all area urologists to apply for privileges in Extracorporeal Shock Wave Lithotripsy. We invite you to visit CAMC and see the lithotripter in action. Come and learn about this revolutionary therapy. We will happily provide you with a brochure for your use as well as brochures for your patients.

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COLLEAGUES IN THE NEWS

WALDEMAR R. AGRICOLA, MD, Newcomerstown, and **ROSARIO MAN-NINO, MD**, Newark, were both honored at the Ohio Academy of Family Physicians for 50 years of medical practice . . . **LINDA E. BAILEY, MD**, Xenia, has been awarded the Edward P. Call, Jr., MD, Teaching Excellence Award from Wright State University . . . **TERRY W. BELL, MD**, Portsmouth, has been appointed laboratory director for the U.S. Health Department of Southern Ohio . . . **MATTHEW R. BISCOTTI, MD**, Parma Heights, has been appointed interim director of Booth Memorial Hospital . . . **JOANNE D. DENKO, MD**, Rocky River, has had a poem published in "Best New Poets of 1987," an anthology of today's poetry . . . **JOSEPH DRAGO, MD**, Columbus, has been named to the Louis Levy Professorship in Cancer by Ohio State University . . . **ALAN L. EDMONSON, MD**, Dayton, has been elected chief of staff-elect at Miami Valley Hospital . . . **JAMES ELLIOTT, MD**, Louisville, has been appointed medical director at St. Luke Lutheran Home for the Aging . . . **PATRICK FAHEY, MD**, Columbus, has been named acting chairperson of the Department of Family Medicine at Ohio State University College of Medicine . . . **WILLIAM FIORINI, MD**, Somerset, has been appointed medical director at

Somerset Quality Care . . . **WILLIAM GATES, MD**, Cincinnati, has been elected to the board of directors of the Cincinnati Area Chapter of the American Red Cross . . . **RAE HARTMAN, MD**, Cincinnati, has been elected to serve as a councilor on the Cincinnati Academy of Medicine Council for 1988-89 . . . **ROBERT G. HERMAN, MD**, Willowick, has been appointed convenient care director for the Chagrin Valley Medical Center . . . **TERRY HUNT, MD**, Oxford, has been re-elected chairman of the board at McCullough-Hyde Memorial Hospital, while **GARVIN McCLAIN, MD**, also of Oxford, has been named chief of staff at the same institution . . . **JOSEPH J. KARIMPIL, MD**, Cleveland, has been named medical director of the Gateway Health Care Center . . . **JOHN G. KRAMER, MD**, Maumee, has been elected chairman of the Ohio State University Hospitals Board . . . **DALE L. MATHIAS, MD**, Peebles, has been elected to the board of trustees of the American Cancer Society . . . **HAGOP MEKHJIAN, MD**, Columbus, has been named assistant vice president of health services at Ohio State University . . . **EMMET P. MONROE, MD**, Cuyahoga Falls, has been selected as Ohio Family Physician of the Year by the Ohio Academy of Family Practice . . . **BUR-**

TON MUST, SR., MD, Dayton, was named 1988 Outstanding Teacher of the Year by the St. Elizabeth Family Practice Residency Class of 1988 . . . **FREDERICK A. PEACHMAN, MD**, Youngstown, has been named medical director of Austintown Surgical Center . . . **CHARLES RUSSELL, MD**, Fairborn, has been named medical director of the Greene County Combined Health District . . . **JACK STARR, MD**, London, has been elected international secretary of the Academy of Hospice Physicians . . . **P. TENNYSON WILLIAMS, MD**, Dublin, has been named Family Practice Educator of the year by the Ohio Academy of Family Physicians . . . Residents of the medical staff at Meridia Huron Hospital were recently presented with annual awards as follows: **JOSE DIAZ, MD**, and **STEPHEN WILLIAMSON, MD**, both of Cleveland, first place for their work on "Hyperbaric Oxygenation Following Experimental Myocardial Infarction"; **KEITH PERRY, MD**, Cleveland, second place for "Treatment of Lower Thoracic Herpes-Zoster Neuralgia: An Innovative Approach"; and **BETH GOLDFARB, MD**, Cleveland, third place for "Complications of Spinal Anesthesia: A Retrospective Study."

CONTINUING MEDICAL EDUCATION

Diagnosis of Infectious Disease by Direct Microscopy

When: Saturday, November 12
Time: 9 AM to 12 Noon

This course sponsored by the Ohio Society of Pathologists.

Speakers:

Leona Ayers, MD, The Ohio State University
Joel G. Lucas, MD, The Ohio State University

Eighth Annual Postgraduate Course in Mental Health Administration

When: November 16-20, 1988
Where: Dayton, Ohio

Credit: 39 hours (category not specified)

Fee: \$450

Sponsor: Department of Psychiatry
Wright State University
School of Medicine

Contact: Paul Rodenhauer, MD
Department of Psychiatry
Wright State University
School of Medicine
P.O. Box 927
Dayton, Ohio 45401-0927
(513) 276-8325

Selected Topics in the Care of the Elderly

When: November 17, 1988

Where: Holiday Inn
1375 West State Route 55
Troy, Ohio 45373

Credit: 7 hours, Category I
Fee: \$60, physicians;
\$30, non-physicians

Sponsor: Upper Valley Medical Center

Dettmer Hospital
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Contact: April Browning, CME Secretary
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IN SUPPORT OF ROUTINE INQUIRY FOR CPR: PART II

James E. Reagan, PhD
James N. Kvale, MD
Irene Santon, RN

Introduction

This is the second and last installment of our proposal eliciting support of Ohio's physicians for the policy of Routine Inquiry for cardio-pulmonary resuscitation (CPR). Last month we presented the concept of Routine Inquiry and discussed its benefits from medical, nursing and ethical viewpoints. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now requires hospitals to implement policies governing utilization of CPR. We suggest that Ohio's caregivers (physicians, nurses, hospital administrators) include Routine Inquiry for CPR as a part of such policy.

How does Routine Inquiry fit into policy about CPR? Who is responsible for implementing Routine Inquiry? For which patients is Routine Inquiry about code status appropriate? What research questions are surfaced in thinking about Routine Inquiry? What is the role of the law in decision-making about CPR? These are pragmatic questions about Routine Inquiry for CPR to which we want to respond in the concluding segment of our proposal.

James E. Reagan, PhD, is a medical ethicist at St. Elizabeth Hospital Medical Center in Youngstown; James N. Kvale, MD, is associate director of geriatrics at the same facility; and Irene Santon, RN, is a former nursing instructor at St. Elizabeth's.

Patient Profile for Routine Inquiry

Which patients should be routinely asked whether they want CPR in the event of cardio-pulmonary arrest? We recognize that this is a challenging question, that it cannot be answered as patly as it is posed. We also realize that proactive discussion about CPR can be unsettling to both recipients of care and caregivers. Yet, patients, families, nurses and physicians are increasingly interested in participating in planned decision-making about life-sustaining treatments and interventions such as CPR. And, JCAHO is requiring hospitals to formulate and implement policies "on the withholding of resuscitative services from patients" (Accreditation Manual for Hospitals 1988 Management and Administrative Services, MA. 1.4.11). Consequently, we think it is better to overtly address the question of patient profile for Routine Inquiry than to covertly presume an unexamined fitness or unfitness for it, and risk seeing policies haphazardly and mistakenly applied.

Routine Inquiry is appropriate for patients who are imminently dying, or who are terminally ill, or whose anomaly/disability is severe and irreversible. We advance this patient profile for Routine Inquiry for the following reasons. First, these are the types of patients for whom the DNR order is presently entered in their chart. Routine Inquiry formalizes a decision-making process currently utilized in writing the DNR order. Second, these are patients for whom CPR might be medically contraindicated, or who might not want CPR for their own

reasons. Routine Inquiry prompts consideration about CPR for these patients prior to indications of arrest, indications which once appearing do not leave time for "considerations." Third, these patients are neither unjustly discriminated against nor harmed by Routine Inquiry. They are not treated unjustly because again, these are precisely the patients whose indications for and attitudes toward CPR should be examined. It is arguably unjust to avoid Routine Inquiry with these patients. They are not harmed by Routine Inquiry because the outcome of a decision-making process is not ordained in advance. Routine Inquiry can conclude that CPR is appropriate for and desired by patients. Asking about CPR does not necessitate inappropriate DNR, whereas not asking often does permit contraindicated CPR, that is to say, permits inflicting harm on some patients.

Responsibility and Policy for Routine Inquiry

We think that the basic responsibility and integrity for Routine Inquiry lies with attending physicians and nurses. In a sentence, physicians should raise the question of code status with certain patients, and nurses should raise the question of the question with physicians. Policy should facilitate these fundamentals. It does not preclude them.

The JCAHO guidelines on acceptable DNR policy are helpful in thinking through Routine Inquiry. JCAHO says that DNR policy be developed consultatively by physicians, nurses and hospital administrators and that it be adopted by hospitals' medical staffs. Policy should spell out a process and protocol for decision-making about DNR. Policy should articulate respective roles of physicians, patients and families, and nurses, and should provide means for resolving conflicts when they occur. Policy should protect the rights and interests of vulnerable patients. Finally, and very importantly, policy should require documentation in the medical record of all the steps in the decision-making process culminating in clarification of a patient's DNR status (Accreditation Manual For Hospitals 1988 Management and Administrative Services, MA.1.411A — MA.1.411.4).

We accept these basic guidelines in thinking through a workable policy of Routine Inquiry for CPR. The rudiments of such a policy are as follows:

- a) Develop patient profiles for Routine Inquiry and notify physicians and nursing services of the profiles.
- b) Identify an agent, e.g. the attending physician, responsible for pursuing Routine Inquiry.
- c) Establish that Routine Inquiry be pursued by responsible agents with appropriate patients in a timely fashion.
- d) Routine Inquiry consists of a discussion between the attending physician and the patient or surrogate decision-maker in which the benefits and burdens and appropriateness of CPR and DNR are considered and the patient's code status is clarified.
- e) The Routine Inquiry discussion should be witnessed by a nurse responsible for the patient. A consent form for code status clarification should be signed by the involved parties.
- f) Routine Inquiry should be documented in narrative progress notes written by the attending physician and the witnessing nurse.
- g) Orders consistent with the Routine Inquiry should be written out in the patient's medical record.

We offer these stipulations as rudiments of a policy of Routine Inquiry, not as a complete blueprint of one. We encourage readers to flesh these rudiments out in manners suitable to their institutional environments. Some physicians might request their

institutional ethics committees (IECs) to explore Routine Inquiry and submit a draft of a policy to the medical staff. Additionally, explicit procedures are needed for determining surrogate decision-makers for incapacitated patients, especially sick elderly patients who are admitted to the hospital from nursing homes in acute conditions. Provisions both for checking and reviewing code statuses of patients already "routinely inquired" should be put in place.

Routine Inquiry and Research

Is Routine Inquiry for CPR a completely new and original concept? No. Routine Inquiry is already implicitly practiced in DNR decision-making. New York has instituted a decision-making process for termination of treatment inclusive of several key points of Routine Inquiry. There are traces of Routine Inquiry, finally, in published writings on many aspects of care for sick and dying patients. Marshall Kapp, JD, MPH, has published a helpful annotated bibliography of pertinent medical literature (Kapp MB. Legal and ethical aspects of resuscitation: an annotated bibliography of recent literature. *Resuscitation* 15 (1987) 289-297).

Research into aspects of Routine Inquiry remains desirable. What are actual treatment and care practices of medical, surgical, oncology, coronary and critical care patients in Ohio for whom Routine Inquiry might be appropriate? Can and should such treatments and practices be standardized, be performed more coherently and consistently, throughout the state? What kinds of communication about code status are already in place in Ohio's hospitals? Are policies and rules being effectively followed? Is documentation sufficient? What are attitudes of Ohio's physicians, nurses, hospital administrators, patients and families about CPR, DNR, code status and Routine Inquiry? How do attitudes influence utilization of CPR in hospitals? What is the impact of CPR utilization on the incomes of physicians? Of hospitals? What are the annual Medicare and Medicaid outlays for CPR in Ohio? These are the kinds of questions needing study and response as Routine Inquiry takes hold throughout Ohio. We invite readers to contact us about research proposals related to Routine Inquiry on which we might collaborate.

The Law and Routine Inquiry

Should there be a law favoring Routine Inquiry? We hear two questions in this query. First, should the Ohio Legislature pass a law explicitly permitting a Routine Inquiry? Second, do Ohio's physicians need such a statute as a condition for pursuing Routine Inquiry with patients and families?

We reply to both of these questions in the negative. We think the Legislature should pass Living Will legislation which includes important provisions of Routine Inquiry. Such legislation would obviate the need for another law specifically authorizing Routine Inquiry. Additionally, we are aware of difficulties stemming from specific laws governing the practice of medicine. Consider the variable of specificity itself. How specifically should a particular statute be written? We do not want the Legislature practicing medicine covertly. Yet, how useful is a highly generalized, non-specific statute to Ohio's physicians? Such statutes invariably beg interpretation, and so increase litigation.

An important reason for not seeking a statute approving of Routine Inquiry lies with physicians themselves. While physicians as a group often voice much interest in law and strong desire for specialized, permissive statutes, they actually soften

their concern for such laws when practicing medicine with individual patients. Our thinking is that physicians have become suspicious enough of the law and of legal processes that they simply disbelieve that individual, permissive, protective statutes actually work in their favor, on their behalf. Physicians conduct their practices in "good faith" according to "reasonable standards" with a modicum of "risk aversion." They do not practice with details of the law in the forefront of their consciousness. Rather, they seek legal advice from lawyers when they feel the need for it, and they more often want to know what the law requires of them or what it prohibits them from doing than what it permits them to do. And to be sure, a statute permitting Routine Inquiry would in all likelihood evolve into a law requiring it. We believe that resentment against yet another legal requirement governing medical practice would grow into rejection of Routine Inquiry in spirit and in practice. For all these reasons we prefer communication, education and policy implementation to statutory law as means of furthering Routine Inquiry in Ohio.

Do Ohio's physicians need a statute as a means of pursuing Routine Inquiry for CPR with patients and families? We think not. Case law in jurisdictions outside of Ohio, and *Leach vs Akron General* from the Court of Appeals of Ohio, Summit County, strongly and consistently support the rudiments of

Routine Inquiry in contemporary medical practice. The headline cases of the last 12 years endorse patients' and families' participation in decision-making about utilizing or foregoing life-sustaining measures such as CPR. These cases mandate consultation and proactive communication between physicians and patients, protection of patients' rights and interests, extensive documentation and clear writing of adequately detailed orders. Ohio's physicians do not need a statute permitting Routine Inquiry because courts from several states have already issued decisions depleting it of risk and effectively approving of it (see *In re Dinnerstein* 38 NE 2d 134, 1978, Massachusetts; *Barber v. Superior Court* 147 Cal App 3d 1006, 1983, California; *Tune v. Walter Reed Hospital* 602 F. Supp. 1452, 1985, United States; *In re Farrell* 108 N.J. 335, 1987, New Jersey; *In re Peter* 108 N.J. 365, 1987, New Jersey).

The authors thank Marshall B. Kapp, JD, MPH, professor in the Department of Medicine and Society of Wright State University, Dayton, Ohio, for critically reading and responding to drafts of these writings. They also thank Cynthia A. Myers, MA, Director of the Health Education Center, St. Elizabeth Hospital Medical Center, Youngstown, Ohio, for editorial assistance.

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Please see following page for brief summary of prescribing information.

THEO-DUR[®]

THEOPHYLLINE (Anhydrous)

Sustained Action Tablets

INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both additional medication, parenterally administered, and close monitoring, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e., nausea and restlessness) may occur frequently when initiating therapy, but are usually transient, when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently, serious toxicity is not reliably preceded by less severe side effects.

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial infarction, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12-hour or sometimes 8-hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the GI tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: **Drug-Drug:** Toxic synergism with epinephrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR 200, 300, and 450 mg Sustained Action Tablets. The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered

1. Every 24 hours in children under 12 years of age, have not been established.

2. Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are

1. Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea
2. Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias

4. Respiratory: tachypnea

5. Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis

6. Other: rash, hyperglycemia and inappropriate ADH syndrome

OVERDOSEAGE: Management: If potential oral overdose is established and seizure has not occurred

- A. Induce vomiting
- B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken)
- C. Administer activated charcoal
- D. If patient is having a seizure
- E. Establish an airway
- F. Administer oxygen
- G. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg
- H. Monitor vital signs, maintain blood pressure and provide adequate hydration

Post Seizure Coma:

- A. Maintain airway and oxygenation
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis, however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert.

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OHIO Medicine

Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be DOUBLE SPACED with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) should bear the figure number and author's name on back. When pertinent, the top of the photograph should be indicated. Do not clip or write on the back of the photos with a hard pencil, etc.

(b). The author should have written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

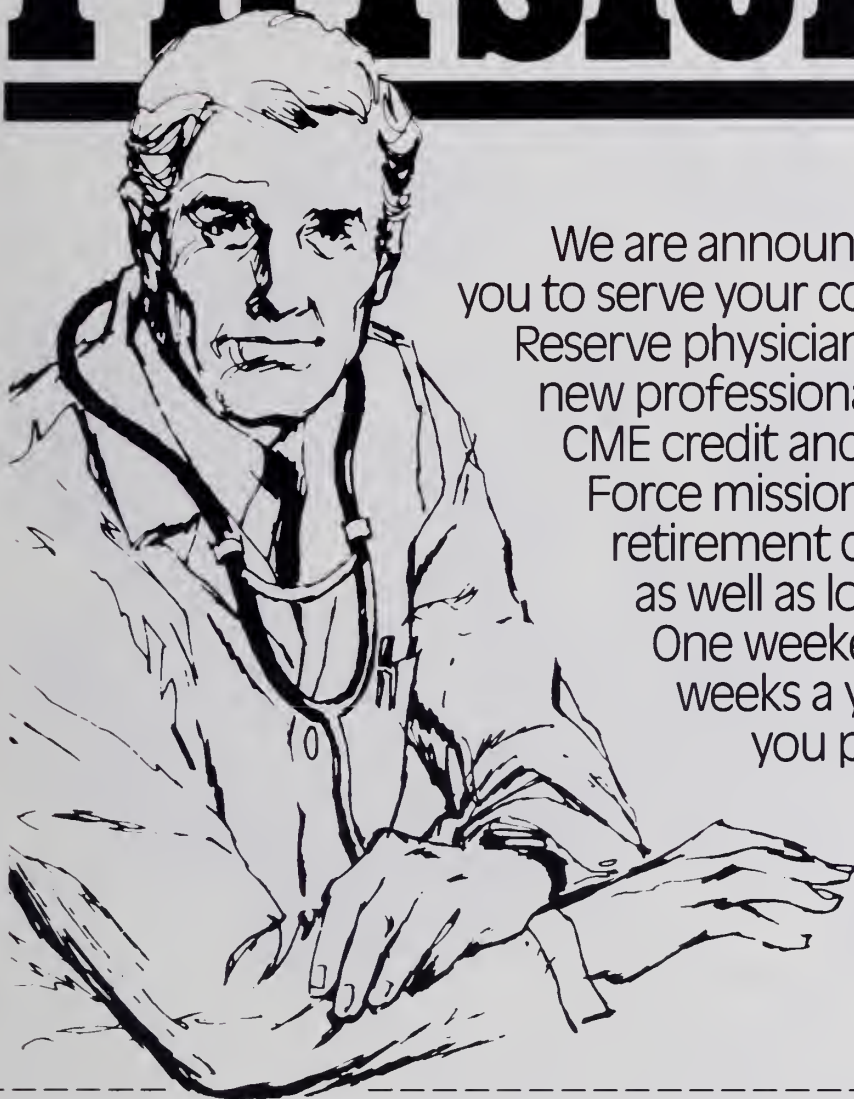
9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

11. **CASE HISTORIES.** The *Journal* does not accept case histories.

12. **EDITORIAL ASSISTANCE.** Michelle Carlson, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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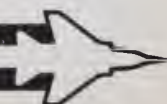
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For respiratory tract infections due to susceptible strains of indicated organisms.

Summary.

Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS. Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Cecilor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Cecilor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea) 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever) 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Cecilor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] [glucose enzymatic test strip, Lilly].

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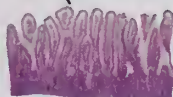


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CARAFATE[®] (sucralfate) Tablets

BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

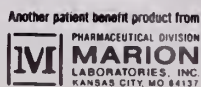
While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Packs of 30 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by Cs on the other. Issued 1/87

Reference:

1. Eliakim R, Ophir M, Rachmilewitz D. *J Clin Gastroenterol* 1987; 9(4):395-399



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OBERLIN, OH — 22-person multispecialty group seeks additional BC/BE family physicians, internist, OB/GYN, dermatologist and orthopedist. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

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Emergency department director is being sought for 40,000+ patient volume emergency department in Greater Cleveland area. Must be Board-Certified in emergency medicine with previous appropriate administrative experience. Benefits package worth 150K, which includes retirement program, comprehensive health package, disability insurance, life insurance, professional liability, continuing education and vacation. Physician is eligible for partnership in two years. Interested individuals, please submit CV to: P.O. Box 2600, Lakewood, OH 44107.

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Emergency department physicians needed for 40,000+ patient volume hospital emergency department in Greater Cleveland area. Physician must be Board-Certified in emergency medicine, residency-trained in emergency medicine, or be Board-prepared in emergency medicine. Salary and benefits package worth \$130K. Included is liability, disability and life insurance, retirement program, vacation, continuing education and comprehensive health coverage. Full partnership eligibility in two years. Interested individuals, please submit CV to: PO Box 2600, Lakewood, OH 44107.

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GENERAL SURGEON: 42-year-old university-trained, Board-Certified general surgeon available November 1988. CV and references available. All locations/positions in Ohio considered. Reply to Box 188, c/o OHIO Medicine, 1500 Lake Shore Drive, Columbus, OH 43204-3824.

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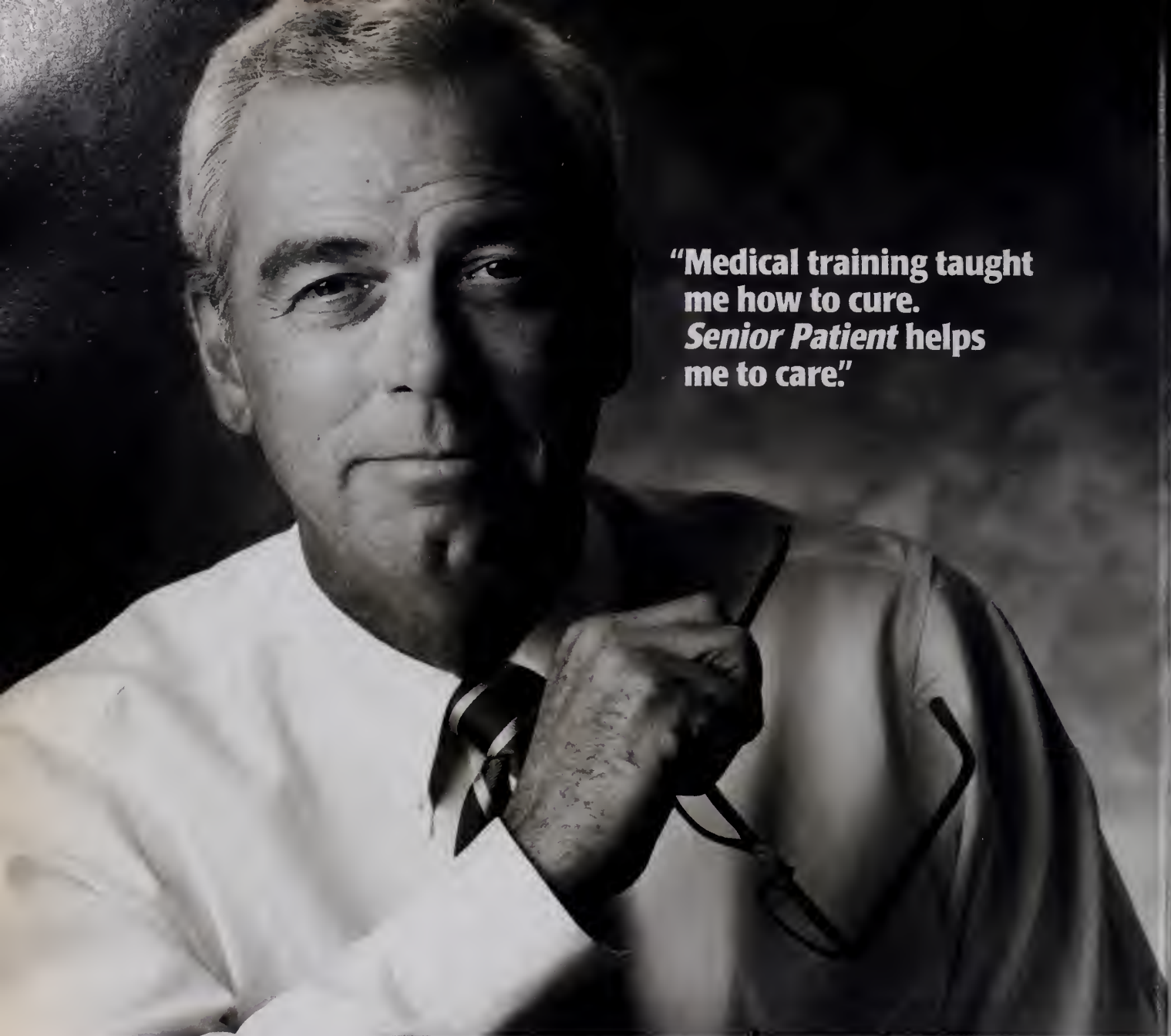
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December 31, 1988 is the deadline — that is when your membership in your county society and the Ohio State Medical Association and the American Medical Association will expire if you haven't paid your 1989 dues.

Your membership in the county medical society, the OSMA and the AMA shows your support for organized medicine and increases its influence on the practice of medicine.

As a member, you are entitled to take advantage of the many benefits offered by the OSMA that are listed on this page.

If you are retired or disabled and are eligible for exemption from OSMA dues payment, notify your society executive director or secretary/treasurer. This exemption will continue annually unless you re-enter practice.

For nonresidents, or those planning to leave Ohio, keep in touch with your colleagues and the activities of the OSMA for just \$40 a year.

For further information about your medical association membership, please contact Katherine Wisse, OSMA Director of Membership Development, at (614) 486-2401.

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AMA Report:

Up-To-Date News From the American Medical Association

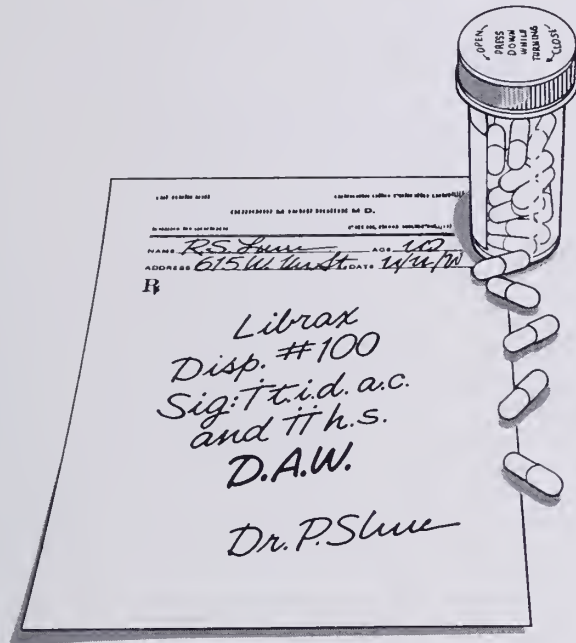
• **AMA opposes psychologists prescribing demonstration...** The AMA recently urged the Department of Defense to cancel an impending demonstration project under which military psychologists soon would be permitted to prescribe psychoactive drugs. The opposition to the project was stated in a letter mailed to William Mayer, MD, Assistant Secretary for Health of the Department of Defense. Psychologists lack the medical training and clinical experience to prescribe psychoactive drugs, and their education does not include adequate training in pharmacology, AMA emphasized. Consequently, psychologists are not well versed on how drugs work, how they may interact with one another or how they are influenced by the overall health status of a patient, AMA said. In addition, they lack the training and clinical experience needed to recognize and properly manage adverse drug reactions. Because of these recognized limitations, not a single state grants psychologists prescribing privileges, AMA pointed out. AMA said the proposed demonstration project, currently scheduled to go into effect later this year, is ill-advised and should be cancelled. The health care of military personnel should not be jeopardized.

• **MAAC warning letters en route...** Medicare carriers soon will be generating warning letters to those physicians who MAY have violated their 1988 Maximum Actual Allowable Charge (MAAC) limitation. HCFA anticipates that between 20,000 and 30,000 such letters will be issued. Physicians in all or parts of eight states already have begun receiving warning notices prematurely issued by seven carriers — Empire and Western Blue Shield in New York, Travelers in Virginia, Nationwide in West Virginia and Ohio, Prudential in Georgia, Texas Blue Shield, and Arkansas and Louisiana Blue Shield. This year, absolute MAAC limits are applicable each time a service is rendered. Last year, physicians were in compliance if their average charges were within MAAC limits. In its discussions with AMA's Washington office staff, HCFA has emphasized that the warning letters are intended to encourage a dialogue between physicians and carriers. It also has advised that recipients of the letters will be subject to intensified monitoring. Refunds will be encouraged where ACTUAL violations have occurred. If physicians negotiate successfully with their carrier, they can avoid having their cases referred to the HHS Inspector General for possible sanctions or fines. The monitoring review process and issuance of letters will be repeated this month. State medical associations that experience any systematic problems in resolving MAAC disputes on behalf of their members should notify AMA's Washington office so that it can work with HCFA in seeking to initiate corrective action. Contact Rich Deem, Department of Federal Affairs at (202) 789-7400.

Health legislative brochure available... Copies of the updated edition of Health Legislative Issues, which the AMA prepares semiannually to define the Association's positions on federal and state legislative issues as well as other health issues of concern to the public, are available free of charge, but availability is limited. Requests for the 71-page publication must be made in writing and should be sent to the Department of Federal Legislation, American Medical Association, 535 N. Dearborn, Chicago, IL 60610.

Unless otherwise indicated, contact the AMA by writing: 535 North Dearborn Street, Chicago, IL 60610
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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such

as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

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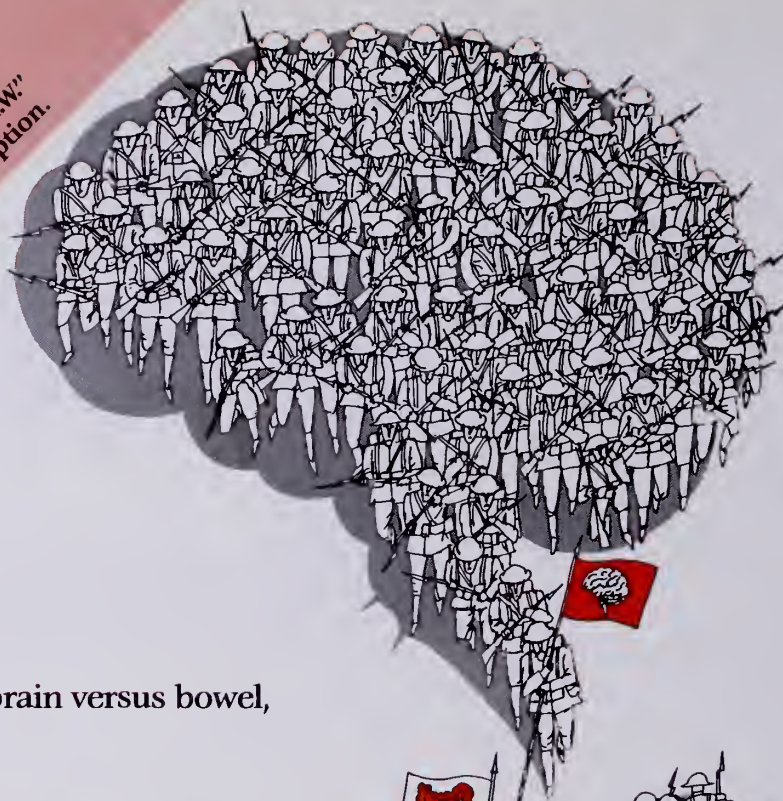
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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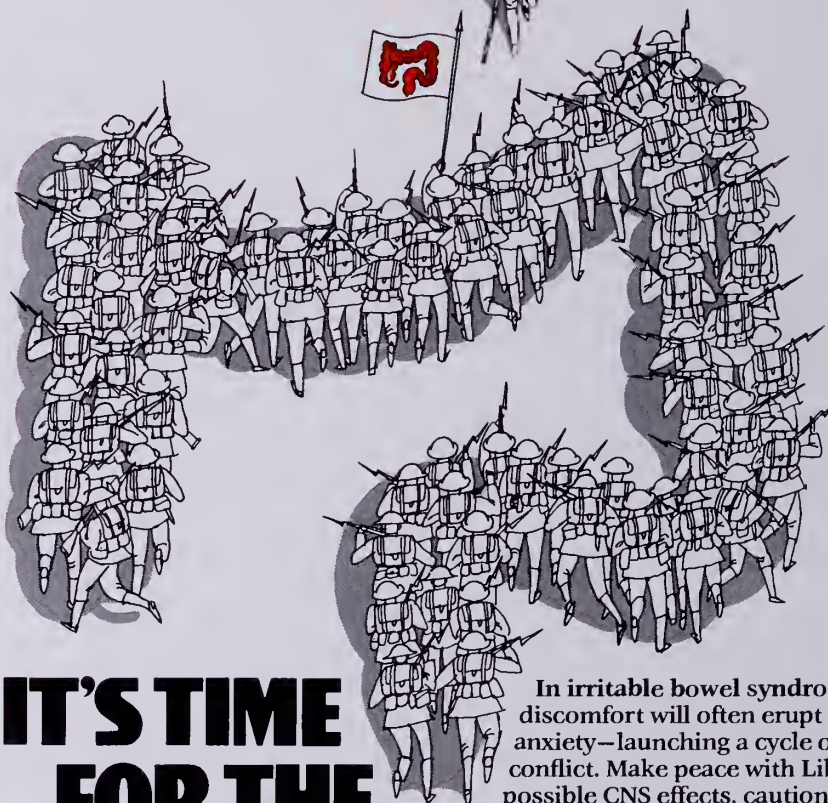
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JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 84. NO. 12

DECEMBER 1988



Ohio's Medically Indigent

How do they cope with today's health-care costs?

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References: 1. Greenblatt DJ, Allen MD, Shoder RI: *Clin Pharmacol Ther* 31:355-361, Mar 1977. 2. Kales JD, et al: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 3. Kales A, et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 4. Kales A, et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 5. Kales A, et al: *Clin Pharmacol Ther* 32:781-788, Dec 1982. 6. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 7. Dement WC, et al: *Behav Med* 5:25-31, Oct 1978. 8. Kales A, Kales JD: *J Clin Psychopharmacol* 3:140-150, Apr 1983. 9. Tennen FS, et al: Symposium in the treatment of sleep disorders; teleconference, Oct 16, 1984.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precaution: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function. Inform patients to consult physician before increasing dose or abruptly discontinuing flurazepam HCl.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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FROM THE EDITOR

Down and Out in Ohio . . . What do you do when you're ill?

In the early part of this decade, Ohio was hit hard with an unemployment problem. Suddenly, thousands of people were out of work, and without medical benefits to help them pay for their illnesses.

The local county medical societies responded quickly, developing programs which linked this new medically indigent population with physicians, hospitals and other health-care providers who would take care of them — and wait until such time as the situation improved for the patient and he or she would be able to pay.

While the situation for many of these individuals did improve, the fact remains that the problem of medical indigency is *still* a problem. There are still people who are losing jobs, or whose health-care benefits are proving to be inadequate. Add to that the fact that the homeless population — at least in Ohio — is growing by 18 percent annually, and you can see that medical indigency remains a dragon to be wrestled with.

In this issue of *OHIO Medicine*, we examine the subject of medical indigency. First, we present the national picture, then we turn around and show how those same points apply to the situation in Ohio. It's a desolate picture to be sure, and yet there are reasons to be optimistic. Deborah Athy and Michelle Carlson, of the *OHIO Medicine* staff, have rounded up from around the state some of the more innovative programs which

have been spawned, specifically, to help the medically indigent, and medical student Ross D. Martin concludes with a look at how some University of Cincinnati College of Medicine students are rolling up their sleeves in an effort to help wrestle the dragon.

This issue will be our last "focused" issue — that is, one in which the major features all relate to one subject or theme. Beginning in January, the editorial content of *OHIO Medicine* will feature more of a mix of articles, ideas, subjects and, we hope, authors. There may still be focused issues if the subject is strong and we find that one article won't be enough to cover its scope — but those will be special issues, not monthly ones. We will be including some light features, some clinical features and, of course, plenty of socioeconomic news. If you have an idea for an article, or, better yet, if you'd like to work on one for us, please let us know. We'd enjoy working with you.

The staff of *OHIO Medicine*, as well as the Ohio State Medical Association joins me in wishing you a happy holiday season. And may all of us look forward to a peaceful 1989.

Karim S. Edwards

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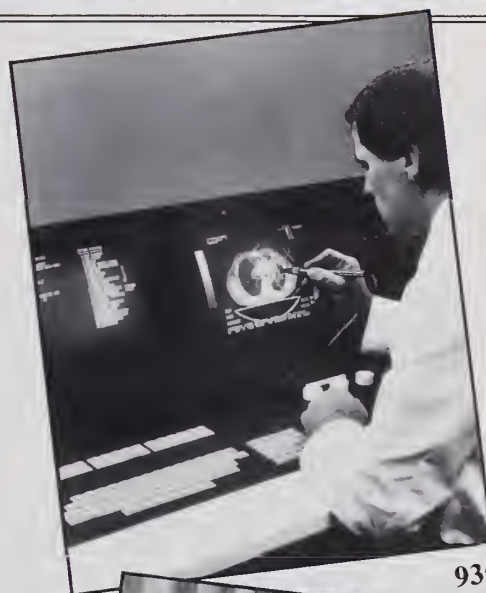
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COVER:

This month's cover was photographed by free-lance artist-photographer Larry Hamill.



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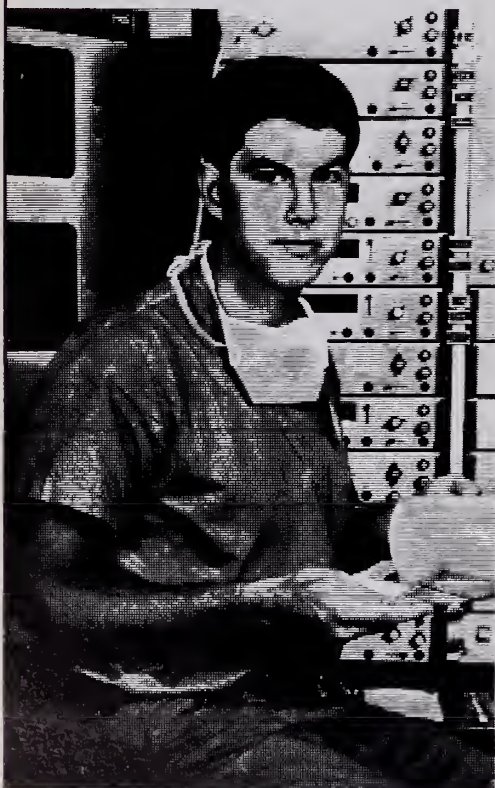


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THE COUNTY COLLECTION

Next month, *OHIO Medicine* will begin a new column, designed to keep you abreast of the latest activities taking place at Ohio's various county medical societies. Our premiere column features Franklin, Lucas and Trumbull counties. Watch for *your* county society's activities . . . coming soon.

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Once Upon a Time . . .

(or 'A Modern Aesop's Fable')

By Donavin A. Baumgartner, Jr., MD
President of the OSMA



he year was 1996 and Americans had just elected a president who promised to

do for the country what he had done as governor in being the first state to provide full food benefits for the entire population. It would be wonderful. No more hunger and no more food costs. Somehow, no one seemed to note that the plan had not yet taken effect and that the state had been losing grocers by the hundreds. The industries that were forced to pay for the added billions were also leaving in a steady stream.

The plan was simple. Everyone would be allowed all food desired to be paid for by food allowances paid for by employers. A surcharge would be added to each company to cover those who were unemployed. Nationally, there had already been instituted a program called "Foodcare" which provided those over age 65 with coverage for 80 percent of what the

government decided should be charged for each item of food. These prices were based on those charged in 1979 with an inflation correction also determined by the government, which amazingly never seemed to be anywhere near the actual inflation rate. The fact that many items were now priced

Blaming the greedy grocers, business began to cut costs by denying "unnecessary food."

by the government at less than the cost of production was supposedly made up by a small "profit" on other items. The public seemed unconcerned that they, as taxpayers, were actually paying for the food costs of a former liberal senator and other multimillionaires.

Business had, several years before, begun paying food bills for

employees. This began as fringe benefits, since it was a non-taxable item for employees and deductible business expenses on the part of industry. Quickly they noted that costs were escalating as employees purchased gourmet items. Blaming the greedy grocers, business began to cut costs by denying "unnecessary" food. At first this included champagne and caviar as well as sirloin, but began to alter to include catsup, pork chops and then milk and bread, unless approved in advance by clerks over the phone referring to lists provided by non-nutritionists. Grocers then were forced to indicate to each individual which items would be paid for by the government and were subject to huge fines if they did not have each purchase accompanied by a signed agreement on the part of the customer to the effect that they understood the regulations and agreed to pay for the item.

The new administration acted quickly and decreed that no grocers would be allowed to do

As complaints began to swell, Congress ignored the problem and added funds to its own particular food supply plan . . .

business unless they agreed to provide all Foodcare recipients with a 50 percent discount. Grocers began to be paid by FRGs or "food related groups." Citizens were not limited as to which foods they could select, but grocers were paid on a flat fee basis. As the Foodcare recipients cleared the shelves of the best foods, the remaining citizens began to note higher prices for "nearmeat" a substitute lauded by the government as better for health consisting of some meat, day-old bread and vegetables as well as "parts" of uncertain origin. When questioned about these items, an informed government source was quoted as saying "parts is parts."

As complaints began to swell, Congress ignored the problem and added funds to their own particular food supply plan that was not subject to the same rules. Citizens began cutting costs by preparing much of their own food but shortages persisted. When told the public was having trouble locating sufficient wheat for use in baking their own bread, the President was heard to say "let them use the microwave brands."

In 1998 food shortages were critical as the masses who had been crossing the border to Canada were prohibited by the building of a high stone wall along the entire border. The public was told that this was a necessary measure to prevent the Canadians from unfair profiteering. Many wondered about this since along the southern borders, one way gates were installed. Grocers had been leaving the industry in droves for other pursuits or as

government "consultants." By 1999, to avoid a certain revolution, Congress impeached the President, but the public had had enough and decided that no Congressperson could serve for more than three terms and that any budget imbalance would be made up in part by using the salaries and allowances of the Congresspersons first.

A remarkable change overcame the country as there was an immediate disappearance of deficits. A new concept of "desirability reimbursement equivalency" for food items was developed. This strikingly new idea held that the amount of desire for any item or service would determine the supply and, therefore the price of that item. The younger population had difficulty in accepting such a radical concept since all schools taught that all demand and all supply is controlled only by the government. Yet, this revolutionary idea began to take hold and rapidly there was a large supply of many foods, including a large number of entirely new items not seen for years.

People began to appreciate that the former liberal senator now had to pay for his own food and miraculously there appeared more than sufficient funds to provide food for those who clearly could not provide for themselves.

As the food problems were solved, the public began to question the generally accepted concept that the federal

government should provide everything to all. In a few years the new idea of "desirability reimbursement" spread to other aspects of society. The USA rose amazingly from the depths of what had been to renewed heights, astounding the Japanese who had begun to lose out in competition to the Chinese as the latter continued to advance their new concepts of business which was not well understood but translated roughly as "undertaking no subject to an arbitrary external force."

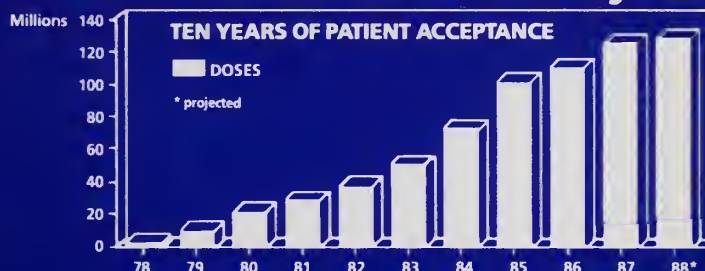
An older citizen leader brashly suggested that these radical concepts might work in other fields such as medicine. The media ridiculed such an idea, Congress scoffed and the former liberal senator suggested that such an idea would be unconstitutional but increasingly, younger citizens questioned these sages and began to whisper among themselves that it might be worth a try. OSMA



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1. Data on file, Knoll Pharmaceuticals
2. Hopkinson JH III. *Curr Ther Res* 24: 503-516, 1978
3. Beaver WT. *Arch Intern Med*, 141:293-300, 1981.

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Please see adjacent page for brief summary of prescribing information.



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:
Allergic-Type Reaction: VICODIN contains sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than non-asthmatic people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. (see ADVERSE REACTIONS: Respiratory Depression).

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: As with any narcotic analgesic agent, VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.
Information for Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex, as with all narcotics, caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1.0 mg/kg q6h, and paregoric 2 to 4 drops/kg q6h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.

Labor and Delivery: As with all narcotics, administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. The antiemetic phenothiazines are useful in suppressing these effects; however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Urteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS.)

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use and the incidence of untoward effects is dose related.

The usual adult dosage is one or two tablets every four to six hours as needed for pain. The total 24 hour dose should not exceed 8 tablets.

Revised June, 1987

5803

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SECOND OPINION

Hot Buttons and Pressure Points — Managed Care

By A. Robert Davies, MD

One of the things that bothers me in the day-to-day practice of medicine is the increasing intrusion of others, not always "significant others," in what used to be nobody's business. The archtypical example of this intrusion is the preadmission certification ritual practiced by insurers, HMO's, PPO's and OWE's¹ attempting to operate managed care programs. This process engenders anger on the part of the conscientious physician; at least it made me angry. I was reminded of this anger during the annual leadership program of the A.S.I.M. last week in Washington, D.C. when a conscientious internist from a small town in Tennessee ventilated on this theme.

"They interrupt the office schedule . . . insist on speaking to me personally . . . ask asinine questions . . . arbitrarily assign

some number of days for the admission . . . call me back during hospital rounds to see why I haven't discharged the patient yet . . . I charge 'em . . . I add it to the patient's bill."

These quotes approximate the ventilated anger. I identified with that. A hot button had been pushed!

I have been thinking about this ever since. What is it that makes us so angry? What is the goal of the people who are doing this to us? Is the goal worthwhile or isn't it? If it is worthwhile, how can we facilitate it without getting mad? If it isn't worthwhile, how can we make them stop it or at least change their behavior so as to make the process tolerable for us? This is the forest I am rarely able to see when the phone is ringing and I have sick people to attend. The trees get in the way.

¹Other Weird Entities.

What makes us so angry? In the first place, we don't like to answer questions or justify our decisions now that we are out of medical school and residency. We had to do that for too long. We didn't like it then and we don't like it now, particularly when the people asking seem to know a whole lot less about it than we do. In the second place, it makes us feel as if we have to ask the teacher for permission to go to the restroom. It is degrading! In the third place, if the patient didn't need to be in the hospital, we wouldn't have ordered it! In the fourth place, how in the world do they expect us to know how long it will take to make this patient's problem go away? I'll send the patient home when they are ready to be discharged! These are at least some of the issues.

What is the goal of the people who are doing this to us and is it worthwhile? The goal must be to discourage hospitalizations in those cases in which another less costly treatment plan would do just as well. Have I ever admitted or held a patient in the hospital when a less costly plan would do just as well? Answer: Not that I can remember. Do others do this? Answer: Someone must do it from time to time or the managed care people wouldn't go to all this trouble. Is the goal of less costly alternatives a laudable one? Answer: Probably, so long as it does no harm.

How can we facilitate this without getting mad? Leave word with our front office that the patient is being hospitalized for such and such reason and we don't know how long it will take until the patient is ready for discharge. Tell our front office people to give that message when the managed care people call. "Doctor said to tell you . . .," etc. Another variation might be to have our front office people call them with the same format. Provide more than enough information. If they still need to talk to us, put them on hold, or better yet have them call us back and put them on hold until convenient to speak with them. There are probably ways of doing the same thing in the hospital. The main idea is to give them the information in a way which is easy for us.

It won't change their behavior to charge them. They either will pay it or they won't. If they don't, the patient will be billed for it and then become the innocent bystander. If they do pay the charge they will really feel entitled to impose on our time and we will begin to feel obligated to respond to the aggravating interruptions.

The pressure point for changing the behavior of the managed care inquisitors is the employee group that purchased the contract with the managed care contractor. Usually employers don't do this sort of thing themselves regarding their employees' hospitalizations. Often the insurers don't even do

this themselves. The "pre-cert and concurrent review" is often contracted to a utilization review firm at so many cents per employee. In order to have the contract renewed next time, the U.R. firm must show that they are worthwhile *and* that they are skilled at their work. Evidence of lack of skill is found in upset employees and upset providers of employees' medical services.

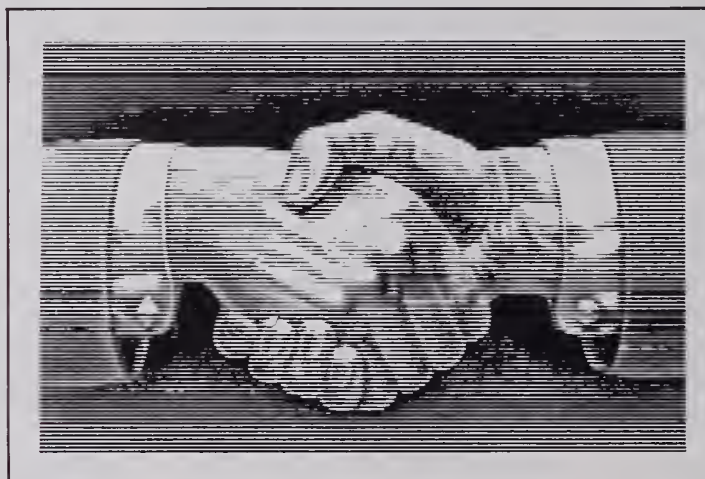
The old axiom "Don't get mad; get even!" holds true. A cool letter to the employer's personnel department or benefits manager along with examples of how the U.R. firm might do its job without making doctors mad and patients embarrassed might just be the most effective pressure point.

We doctors (speaking for myself at least) have never hesitated to tell others how to do their jobs. Why should the U.R. firms be spared?

A. Robert Davies, MD, Columbus, is a member of OSMA's Committee on Communications.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of Ohio Medicine or the Ohio State Medical Association.

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LETTERS TO THE EDITOR

Kudos for Communications

To the Editor:

Every state medical association should have a Ms. Carol Mullinax!

Huron County physicians were given an unusual challenge and "treat" in the recent three-hour Communications Seminar given by Ms. Mullinax at Fisher-Titus Medical Center, Norwalk, Ohio.

Any county, medical staff, district, or group of doctors who have not attended Ms. Mullinax's seminar on how to present the issues and answer and challenge the media are missing a real treat.

Freedom is EVERYONE's responsibility. The work should NOT be left up to the President, Delegate, Secretary, Councilor, Society, etc., etc. Freedom's blessings accrue to all. Freedom's responsibilities must be shared, supported and adjoined by all.

Please do it today. Call the OSMA, ask for Ms. Mullinax, and do schedule your Communications Seminar for your staff and/or county medical society.

A-C-T-I-O-N on the offense safeguards, protects and advances freedom.

N.M. Camardese, MD
Delegate, OSMA
President, Americanism Fdn.
Norwalk

Distasteful photo

To the Editor:

The photo used in the article "Hospital Medical Staffs" (*OHIO Medicine*, Vol. 84, No. 8, August, 1988) was offensive. Doctors must use logic to persuade, not handguns.

Yes, you caught my attention, but in a negative manner.

Sincerely,
L.P. Baldoni, MD
Perrysburg

Favored topics

To the Editor:

May I express my appreciation and thanks to you for the following two timely articles in *OHIO*

Medicine for September 1988:

1. G. Dixon Clouse, MD: "Why People Don't Take Their Medicine"
2. National Childhood Vaccine Injury Act

The article by Dr. Clouse refers to a problem which all of us in practice face. I am so pleased that he was able to present such a down-to-earth article on such an important problem.

The Vaccine Injury Act, of course, is most important. All of us know that vaccine injections can be associated with annoying complications — sometimes even disastrous (ones). Nevertheless, because of the overall unquestionable good effect of such vaccines, their administration must be continued. By the national government protecting those who give such vaccines, we can continue our very effective vaccination programs, such as the tetanus toxoid program, which is making tetanus a disease of only historical significance in the United States.

Sincerely,
Wesley Furste, MD
Columbus

Editor's note: *We wish to note that, despite its name, the National Childhood Vaccine Act, which describes the requirements for permanent records and for reporting events after vaccination, applies to all individuals who are vaccinated, regardless of their age at the time of vaccination.*

OHIO Medicine Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this journal. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, *OHIO Medicine*, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be **DOUBLE SPACED** with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) should bear the figure number and author's name on back. When pertinent, the top of the photograph should be indicated. Do not clip or write on the back of the photos with a hard pencil, etc.

(b). The author should have written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections, sign the galley and return.

11. **CASE HISTORIES.** The *Journal* does not accept case histories.

12. **EDITORIAL ASSISTANCE.** Michelle Carlson, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians

In vitro clinics — next to be regulated?

In vitro fertilization clinics may be the next item to come up for federal regulation now that the high-tech technique has evolved into a burgeoning \$66 million industry.

Currently, some two to three million couples in the United States are infertile, and although the incidence of infertility appears stable, the number of office visits for infertility services nearly tripled between 1968 and 1984. Newly released statistics, however, reveal that nearly half the estimated 175 in vitro fertilization centers that have been established in this country to meet demand for IVF services have never produced a single baby. In fact, critics say, infertile couples who believe that their chances of giving birth through in vitro fertilization are as high as 30 percent frequently emerge from these clinics childless, despite pouring thousands of dollars into the effort — realizing, too late, that the average success rate per single attempt may be as low as 6 percent.



Meanwhile, those in the IVF community, and some consumers, are arguing that rigid rules and regulations could hamstring the industry at a crucial stage in its development.

A congressional subcommittee in Washington is holding hearings on the extent of exploitation of infertile couples, as well as on emerging reproductive technologies and the ethical questions they raise.

Report on controlling hypertension now available

The National Heart, Lung and Blood Institute (NHLBI) announces that its 1988 "Report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure" (JNC IV) is now available for distribution. The report was recently released by the coordinating committee of the National High Blood Pressure Education Program, a program sponsored by the NHLBI. This represents the fourth in a series of these reports which have provided recommendations for more than a decade.

JNC IV reviews, updates and expands the 1984 recommendations for controlling hypertension. The new report translates the results of the latest clinical trials to medical practice; addresses the needs of special populations; examines factors that influence the cost of care; and provides additional guidelines for managing high blood pressure in the presence of cardiovascular diseases and other coexisting medical conditions. It is intended as a guide for practicing physicians and other health professionals in their care of hypertensive patients and as a reference for those participating in the many community high blood pressure control programs throughout the country.

A copy of JNC IV may be obtained free of charge by contacting: The National High Blood Pressure Education Program Information Center, 4733 Bethesda Avenue, Suite 530, Bethesda, MD 20814, (301) 951-3260.

Interest in nutrition sagging

Students who begin medical school believing that studying nutrition will benefit their careers (74 percent) eventually lose their positive attitudes by the time they finish their medical studies, according to R.L. Weinsier, MD, of the University of Alabama at Birmingham.

In a paper presented in October at the American Dietetic Association's 71st Annual Meeting

in San Francisco, Dr. Weinsier revealed that only 13 percent of medical students still believe knowledge of nutrition is important at the end of their training. However, he noted that his study, which involved students from 11 medical schools, also shows that when nutrition is incorporated into a medical school's regular curriculum, students tend to view it as important.

Biochemical marker detected in alcoholics



A biochemical marker that can be used to distinguish alcoholics from non-drinkers has been discovered by two researchers in California.

Drs. Adrienne Gordon and Ivan Diamond, of the Ernest Gallo Clinic at the University of California, San Francisco, report that blood studies the pair conducted recently reveal that blood cells of alcoholics respond differently to alcohol than do blood cells of non-drinkers — even those cells cultured for four generations.

The key to the researchers' discovery appears to be a chemical called cAMP, which is found in every cell of the human body and is necessary for almost all metabolic functions.

Dr. Gordon explains that "almost all receptors that affect cAMP production are affected by ethanol. In the presence of ethanol for short periods of time, you get a marked increase in cAMP."

Alcoholics, however, appear to have adapted to alcohol so well that their levels of cAMP do not soar as would be expected.

The distinguishing characteristic, Dr. Gordon says, is that when the cells are no longer exposed to alcohol, non-drinkers' levels of cAMP return to normal. But in alcoholics, cAMP levels drop to about 75 percent below the norm, which, Dr. Gordon says, "could explain alcohol withdrawal."

The researchers believe their findings would be most useful if applied to teen-agers: By measuring those patients' levels of cAMP, Dr. Gordon says, physicians would be able to predict which teen-agers are most susceptible to alcoholism.

Furthermore, she says, "Many patients come in with disease problems stemming from alcoholism, but they deny they ever abuse alcohol. So doctors could benefit from a simple blood test like this."

Academy of Medical Directors to merge

The American Academy of Medical Directors (AAMD) recently announced its plans to assume the name of its affiliate, the American College of Physician Executives (ACPE). The two professional health-care associations are expected to merge operations on Jan. 1, 1989.

Michael B. Guthrie, MD, current president of the AAMD, has called the merger "an exciting and vital development in positioning our emerging profession for what we believe is the inevitable recognition of medical management as a specialty of medicine."

While some in the industry have questioned why the country's fastest growing professional health-care association would choose to change its name, Roger Schenke, executive vice president of the AAMD, defends the Academy's action, saying it reflects its rapidly expanding constituency.

"While medical directors are still the core of our organization," Schenke explains, "the explosive part of our growth is coming from vice presidents of medical affairs, chief executive officers, chiefs of service and department chairs from all sectors of the health-care field."

Furthermore, he says, "Our board and members firmly believe that changes are inevitable and necessary to maintain leadership positioning. Most organizations operate from an 'If it ain't broken, don't fix it' mentality . . . We strongly adhere to the opposite philosophy: Change should be made from a position of strength, not weakness."

The new College will assume the AAMD's seat in the American Medical Association's House of Delegates as the national specialty society representing the interests of physicians in leadership, management and administration.

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Summary.

Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthritis, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hyperkalemia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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COLLEAGUES

CURTIS L. CAUGHEY, MD, Las Vegas, has been named director of emergency services at Piqua Memorial Medical Center . . . **JERRY GUY, MD**, Columbus, has been named medical director of oncology of the new cancer center at Saint Anthony Medical Center . . . **RAY E. KIEFHABER, MD**, Middletown, has been elected vice chairman of the Middletown board of trustees . . . **GLEN McPHERON, MD**, Cincinnati, has been promoted to senior vice president of quality assessment and medical affairs at Bethesda Hospital . . . **ANTHONY MONTANARO, MD**, Cleveland, has been named medical director of the North Olmsted MED Center . . . **F. JAY ACH, MD**, Cincinnati, has been elected president of the Ohio Academy of Family Physicians . . . **P. HUNTER PECKHAM, MD**, Chagrin Falls, has been named director of the Rehabilitation Engineering Center for Functional Electrical Stimulation in Cleveland. The center was recently created after researchers were awarded \$2.5 million by the National Institute on Disability and Rehabilitation Research . . . **JAMES McWEENEY, MD**, Mariemont, has been appointed medical director of the Middletown Social Services and Health Center . . . **ROBERT H. OSHER, MD**, a Cincinnati ophthalmologist, has been honored for his surgical skills by a European organization of physicians who specialize in cataract and implant surgery . . . **ROBERT P. JACOBSEN, MD**, Cleveland, has been appointed medical director of the division of medical imaging and radiologic sciences at Meridia Hillcrest Hospital . . . **RICHARD SABRANSKY, MD**, Westlake, has been named medical director of CIGNA Healthplan of Ohio, Inc., Northeast Ohio Division . . . **REBECCA JACKSON, MD**, Columbus, a paraplegic endocrinologist, has been honored by the Pilot Club of Columbus as its Disabled Professional Woman of the Year . . . **STEVEN GABBE, MD**, Columbus, chairman of the obstetrics and gynecology department at University Hospitals, and **FRED ZUSPAN, MD**, Columbus, a professor in the same department, have been listed in *Good Housekeeping* magazine as two of the "107 Best Doctors for Women" in the United States . . . **HENRY J. HEIMLICH, MD**, Cincinnati, has received the 1988 Americanism Award from the China-Burma-India Veterans Association . . . **JACK RUBINSTEIN, MD**, Cincinnati, has received the first Citizen Advo-

cate Award from the Ohio Governor's Office of Advocacy for Handicapped People . . . **GEORGE A. NANKERVIS, MD**, Akron, has received the 1988 Pediatric Recognition Award from the Ohio Chapter, American Academy of Pediatrics . . . Barberton Citizens' Hospital's new medical library has been named after **EDWARD F. MORRIS, MD**, an Akron radiologist . . . **LOUIS J. GOETZ, MD**, Bellbrook, has been named medical director of St. Leonard Center's new Health and Rehabilitation Center . . . **THOMAS F. MEANEY, MD**, Cleveland, has been installed as the 1988-89 president of the American College of Radiology . . . **JAMES J. ANTHONY, MD**, Cincinnati,

has been installed as the 132nd president of the Academy of Medicine of Cincinnati . . . **J. CRAIG STRAFFORD, MD**, Gallipolis, has been elected Eastern Region Representative for the American Group Practice Association's board of trustees . . . **DOREEN DUPONT, MD**, St. Clairsville, has been named president and medical adviser of the American Cancer Society's Belmont County Unit . . . **BERNARD S. ABRAMS, MD**, Chagrin Falls, has been named to the reactivated Governor's Traffic Safety Committee . . . **MOON H. KIM, MD**, Columbus, and **WILLIAM H. SAUNDERS, MD**, also of Columbus, have received faculty teaching awards from The Ohio State University.

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Community Mutual Becomes The Blue Cross & Blue Shield Carrier For Ford-UAW And Other Hourly Enrollees And Retirees In Ohio.

Beginning January 1, 1989, Community Mutual will be the only carrier for Ford-UAW and other hourly enrollees and retirees for traditional hospital-surgical, medical, prescription drug and hearing benefits administered statewide.

All claims for Ford-UAW and other hourly enrollees and retirees should be sent to: Community Mutual Blue Cross & Blue Shield, Automotive Business Division, P.O. Box 700, Worthington, Ohio 43085.

After January 1, 1989, please be sure that you ask to see the new enrollee identification cards. Except for maternity, precertification is required for all hospital admissions, including psychiatric and substance abuse. The new precertification number to call is: 1-800-338-8479.

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OHIO MEDI-SCENE

*Fifty-year physicians honored . . . AIDS statistics for Ohio . . .
MacSurgery . . .*

OSMA salutes its 50-year physicians

In 1938, the physicians listed below were recent medical school graduates — anxious to begin their medical practices and to treat their first patients. While much has changed in medicine over the past 50 years, the dedication and drive of these physicians has not.

The Ohio State Medical Association extends its heartfelt congratulations to each of these 1938 medical school graduates, and salutes the half-century of service that they represent.

First District

Irwin Charles Albert, MD,
Cincinnati
Robert John Anzinger, MD,
Cincinnati
Charles M. Barrett, MD,
Cincinnati
William C. Beck, MD, Oxford
Lewis Patrick Brumm, MD,
Cincinnati
Clyde G. Chamberlin, MD,
Hamilton
Paul E. Foldes, MD, Cincinnati
Eugene Paul Fromm, MD,
Cincinnati
Clifford G. Grulee, Jr., MD,
Cincinnati
Howard M. Hunter, MD,
Hamilton
Jules Isaac Klein, MD, Cincinnati
Benjamin J. Lehmann, MD,
Hamilton

Franz Josef Nave, MD, Cincinnati
W. Donald Ross, MD, Cincinnati
Morris Louis Stein, MD,
Cincinnati
Anna Jenia Weinstein, MD,
Cincinnati

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Jefferson, TX
David Hoehn, MD, Jefferson, TX
Else M. Krug Weyman, MD, Ft.
Myers, FL
Mervin F. Steves, MD, Sun City
Center, FL

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Herbert R. Cammerer, MD,
Dayton
Edith Gitman, MD, Dayton
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Alan S. Horwitz, MD, Dayton
Herman Michael Lubens, MD,
Dayton
Jerome S. Surdyk, MD, Dayton
Frank C. Sutton, MD, Dayton
H.C. Van Kirk, MD, Dayton
Charles M. Oxley, MD, Troy
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Morris B. Martin, MD, Springfield

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Naples, FL

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Raymond Paul Epstein, MD, Lima
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Salvatore J. Novello, MD, Lima
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Charles Donatelli, MD, Toledo
Robert Charles Fox, MD, Fremont
Spencer W. Northup, MD,
Sylvania
Johnston F. Osborne, MD, Toledo
Leo Weiss, MD, Toledo
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Lambertville, MI
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Falls

OHIO MEDI-SCENE

50-year physicians . . . continued

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Domenico Fragomeni, MD,
Richmond Hts.
Jerome Arthur Gans, MD,
Cleveland
Richard Paul Glove, MD,
Cleveland
Evelyn Frances Golomb, MD,
Mayfield Hts.
Joseph M. Kaplan, MD, Cleveland
Middleton H. Lambright, MD,
Euclid
Leonard Levin, MD, Cleveland
Anne S. Master, MD, Cleveland
John Robert Master, MD,
Cleveland
Alexander John Pasterak, MD,
Cleveland
Robert Ralph Richards, MD,
Westlake
Robert S. Rosner, MD, Cleveland
Paul Joseph Schildt, MD,
Lakewood
William Lee Schlesinger, MD,
Cleveland
A. Benedict Schneider, Jr., MD,
Cleveland
David Shallenberger, MD,
Chesterland
Francis F. Silver, MD, Cleveland
Howard A. Steiner, MD, Cleveland
Benjamin H. Sullivan, MD,
Cleveland
Sam Tetelman, MD, Warrensville
Fred Ruhl Tingwald, MD,
Cleveland
Elizabeth Workman Lash, MD,
Willoughby
Edward M. Zucker, MD, Cleveland

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Beach, VA
Hudson D. Fowler, MD, Naples,
FL
Frank L. Meany, MD, St. Louis,
MO
Robert H. Mooney, MD, Barefoot
Bay, FL
Hugh Aloysius O'Neill, MD, St.
Petersburg, FL
Thaddeus Pogorski, MD, Raton,
NM
Linda T. Schneider, MD, Chicago,
IL
William Shapero, MD, Boca
Raton, FL
Malcolm E. Walker, MD, Kewadin,
MI

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Albert Joseph Gilbert, MD, North
Canton
Howard James Ickes, MD, Canton
Sol Klatman, MD, Warren
Francis G. Kravec, MD,
Youngstown
Frank M. Lindsay, MD,
Homeworth
Alexander K. Phillips, MD,
Youngstown
C. Edward Pichette, MD,
Youngstown
Milton M. Schindler, MD, Canton
John Howard Thomas, MD,
Warren
Karl Stephen Ulicny, MD, Salem

E. Merle Weaver, MD, Canton
Albert L. Williamson, MD, Niles

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Springs, CA
Alfred Smits, MD, Seminole, FL
William Emil Sovik, MD, Palm
Harbor, FL
Isydore Werbner, MD, Hallendale,
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Otto Selick Steinreich, MD, Akron

Fred F. Somma, MD, Cuyahoga
Falls

Norman E. Wentsler, MD, Akron

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Huntingdon Valley, PA

Edward F. Hellwig, MD, Winter
Park, FL

Alexander L. Kinbau, MD,
Crawfordville, IN

AIDS and Ohio — the statistics

As of August 1, 1988, Ohio has had 930 cases of AIDS reported, with a 57% (522) fatality rate, making the state number 13 in the total of AIDS cases reported throughout the country. New York still leads with a current total of 16,890 cases, followed by California (14,499), Florida (5,060), New Jersey (4,628) and Texas (4,560).

AIDS continues to affect the 30-39 age group the hardest, but totals in the 13-19 age group and the 20-29 group have risen slightly over the last year.

ARC cases now number 146 in Ohio.

Cuyahoga remains the Ohio country with the greatest number of AIDS cases — 53 so far this year, compared with 39 in Franklin and 19 in Hamilton. Montgomery County has had 12 cases reported this year.

Gay/bisexual males continue to be the greatest source of transmission of AIDS in Ohio (69%), followed by IV drug use (7%) and a combination of homosexual activity/IV drug use (5%).

MacSurgery

Time was when a medical student sat down with a stack of medical books to study. But times have changed.

During a surgical residency at the University of California, Joel Weinstein, MD, grew tired of the same old study habits. Buried under a pile of books, medical references and anatomical drawings, he turned to a personal computer for inspiration.

Dr. Weinstein, now an assistant professor of surgery at Case Western Reserve University (CWRU), transferred the text and diagrams from one of his medical books to a computer and connected the computer to an already existing video disc of surgical procedures.

This was the beginning of one of the first computer video-disc databases for clinical medical education in the country, the Surgical Hypermedia program. The computer program, a.k.a.



OHIO MEDI-SCENE

MacSurgery . . . *continued*

MacSurgery, currently consists of four medical lessons:

(1) Appendectomy for Acute Appendicitis; (2) Trauma Management; (3) Recurrent Small Bowel Resection for Crohn's Disease; and (4) The Use of Staplers in Colon Surgery.

Dr. Weinstein, also a surgeon at Cleveland Metropolitan General Hospital, hopes to expand MacSurgery with additional surgical programs, databases and anatomical drawings. Eventually, everything you ever wanted to know about medicine, but couldn't fit on the top of your desk at one time, might be neatly catalogued and stored on cardboard-thin computer discs.

The programs are not as flashy as a video game, but they're bound to be as challenging . . .

The programs are probably not as flashy as a typical video game, but they're bound to be every bit as challenging. Dr. Weinstein believes the study programs should interest post-graduate surgeons as well as medical students and residents.

"MacSurgery allows the surgeon to use the video as a reference source" by giving quick access to any segment of the operation. For example, "A surgeon may want to refresh his memory before going

into the operation room on different suturing techniques used for an appendectomy," he explains.

MacSurgery gives the medical student a dress rehearsal of sorts before the real thing . . . an opportunity to smooth out the rough edges. "It takes awhile before a person can get used to seeing an operation," says Dr. Weinstein. A run-through on the computer may help students to curb some of their anxiety about the operation, while answering their questions at the same time. Thus, fainting spells, anxiety attacks and last-minute questions can be quelled before the student steps into the operating room.

MacSurgery stations are currently in use at CWRU School of Medicine and Cleveland Metropolitan General. Dr.

Weinstein is working to have the programs included in CWRU's current medical curriculum and hopes to see more computer stations set up in the near future.

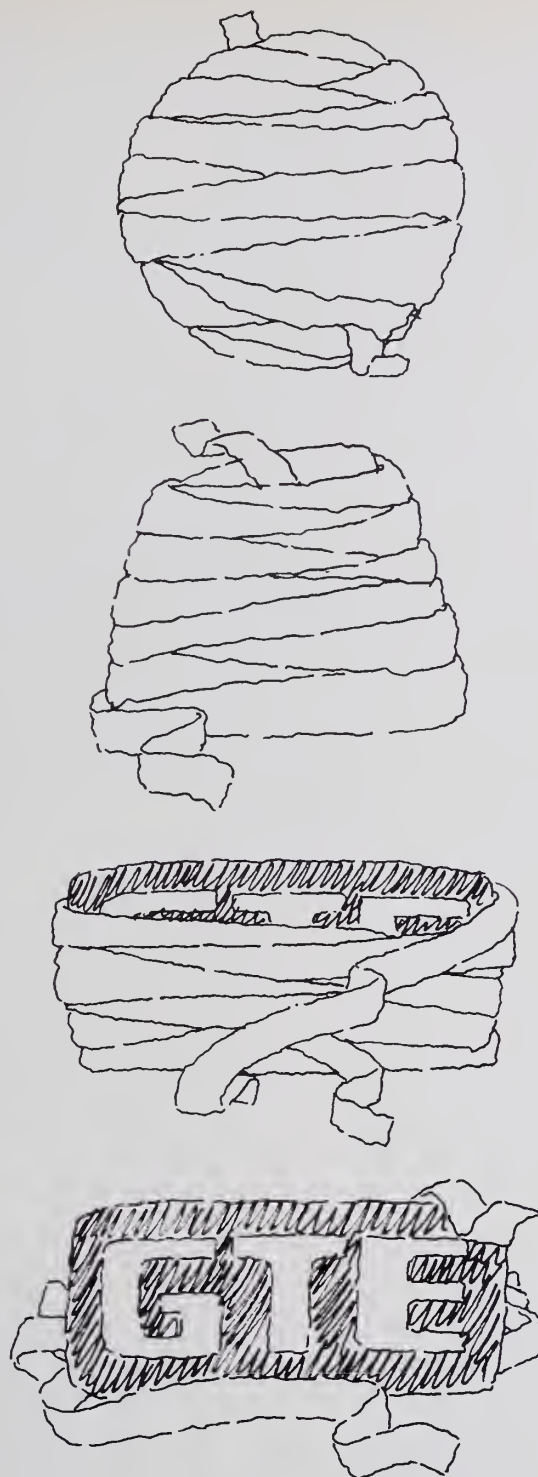
The main drawback of MacSurgery is its cost, which totals about \$9,000 per station. But computer companies have been chipping away at the financial restraints with several recent donations, including four 19-inch color monitors and a memory expansion kit.

In the meantime, Dr. Weinstein has been taking his particular brand of computer science on the road to medical and computer conventions. He plans to present MacSurgery at this year's annual meeting of the American College of Surgeons. — *Deborah Athy*

Looking for the latest AIDS facts? . . . AIDSLINE may help

The National Library of Medicine and the NIH Office of AIDS Research now offer a new database which contains some 13,000 references to scientific articles about AIDS, including clinical and research aspects of the disease, epidemiology and health policy issues. Many of the records include an abstract in English. The articles cover the period 1980 to the present, and the database is updated twice each month with the addition of 200-300 records.

Telephone inquiries about AIDSLINE may be made to NLM's MEDLARS Management Section (301) 496-6193 or (800) 638-8480. The National Library of Medicine also publishes a quarterly AIDS bibliography that lists references by subtopics. Subscriptions (\$12, \$15 foreign) may be sent to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.



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THE POWER IS ON

A National Perspective

The Medically Indigent

*How do they cope in today's
high-tech, high-cost health world?*

It's midnight, and the city sleeps — despite the heat that baked the streets all day and threatens, now, to suffocate anyone who remains within its grasp.

Above, fans whirl in the open windows of tenement buildings and middle-class apartments in vain attempts to coax some movement from the thick, stale air, while below, the city's homeless sprawl across darkened doorways and in forgotten alleys — their alcohol-induced stupors making them blessedly oblivious to the discomforts of the night.

Tomorrow, they'll wake up — these city people — and reality will be theirs again, with all of its pains and disillusionments. Tomorrow, some will make their way to clinics and hospital emergency rooms, hoping for a small measure of relief from their

more physical distresses. Most, however, will not seek medical care. Knowing they cannot pay for the service — let alone whatever treatment might be prescribed — is a hurt they can live without.

The problem, of course, is that more and more Americans are fitting into this class known as the “medically indigent” — those who lack health insurance or enough health insurance to pay for their medical care.

To date, an estimated 35 million Americans presently have *no* health insurance coverage (up 25 percent from 1975 figures), and an additional 16-17 million are drastically *underinsured*. As a result, an entire class of people in our society is receiving little, if any, medical care.

Who are these people likely to be?

By Karen S. Edwards





An estimated 100,000 American children are said to wander the streets on any given night, though many believe that figure is greater.

There *was* a time when the profile of someone medically indigent might have read like this: single man, mid- to late-50s, most likely a transient, suffering from alcoholism, drug addiction, maybe both. He could be found at any of the downtown bars, pool halls, flop houses or skid row areas that exist in most large cities.

But times have changed, and so have the people who have fallen onto hard times. Now the poor, and a new subgroup called the “working poor” are composed of a wide scope of individuals.

The homeless and unemployed still comprise a large section of this group — there is no mistaking that. But the characteristics of the homeless have changed in the past few years.

For one thing, the homeless are no longer all men.

An increasing number of reports now reveal that women are rapidly becoming the newest members of the homeless class, especially single women heads of household who, surveys reveal, are typically in transition from unsatisfactory housing arrangements (or marriages) to establishing new households.

The lack of low-cost permanent housing, however, is a stumbling block for many of these women, as is the personality factor that emerges when such roadblocks are met.

A survey of homeless families

recently conducted by a Harvard psychiatrist explains this factor more fully:

“Many of the homeless women exhibited an inability to achieve or maintain an independent adult existence. Most had sporadic or non-existent work histories, no stable, reliable relationships or supports, and, in some cases, no consistent pattern of housing — even in those rare situations in which housing was available.

“Once on the streets, the problems of homeless mothers are greatly magnified, and for many, become insurmountable. The sheltering facilities are just another brief stop in a long-term pattern of instability . . . The cycle itself is responsible for generating an intense and debilitating pattern of emotional distress, despair and hopelessness among mothers and children alike.”

Children, in fact, add yet another dimension to the homeless population and, like women, are among its fastest growing segment.

Many, of course, are part of the homeless families now on the streets — estimated to be more than one-third the total homeless population in America. Others, however, are runaways or what have become known as “throwaways,” the child tossed out onto streets by angry, frustrated or desperate parents. An estimated 100,000 American children are said to wander the

streets on any given night, though many believe that figure is much greater.

What many social experts now fear, however, is that these children, raised in unstable environments, will in turn pass this type of unsettled restlessness onto *their* children, until soon, homelessness emerges as a transgenerational legacy — perpetuating the problem for years to come.

Yet even if the homeless situation could be eradicated in the next year or two, the medically indigent would still be present.

As has already been pointed out, there are between 16 and 17 million people who can be counted among America's working poor. These people have homes and jobs that offer health-care benefits, but as health-care costs spiral upwards, out-of-pocket expenses become greater, and for those on low incomes — unaffordable.

Some sources indicate nearly 2 million families each year experience out-of-pocket medical costs higher than \$3,000 — enough to totally disrupt the family budget of those 80 percent of Americans who have no liquid assets.

A different scenario, but one which also accounts for a greater class of the working poor, is the employer who, faced with high insurance premiums, institutes one

of the following cutbacks at his or her place of business: switching employees to a co-insurance plan (usually 20 percent); adding or increasing deductibles; or requiring the employee to pick up all or most of the premium for new coverage. As a result, the employee is now footing a greater piece of his or her health-care bill — but if that money has not been budgeted for by the family, it often is not there.

Meanwhile, government programs such as Medicaid are of little help to those who have jobs and, presumably, the benefits and money to pay doctors, hospitals and laboratories on their own.

The working poor are not the only groups in this dilemma, though.

Naturally, the elderly, on fixed incomes and in need of long-term care, also fall into this class, as do the victims of catastrophic illnesses such as AIDS.

AIDS has, in effect, created an entirely new group of medically indigent in America — not only because of the expense of care, but because workers with AIDS are frequently terminated from their jobs — and their health-care benefits.

Presently, 10 states — Connecticut, Florida, Illinois, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island and Wisconsin — guarantee

health insurance to *all* residents, including AIDS victims, but the premiums are higher, generally 2 to 2½ times those of comparable private policies.

Too often, however, the AIDS patient reaches the end of his or her benefits, as well as life's savings, before the full extent of the affliction runs its course, so it's a small wonder that many of today's AIDS patients frequently appear in AIDS shelters — adding yet another new segment to the burgeoning homeless population.

Yet, as the uninsured and underinsured population continues to grow, the access to the health-care system for the medically indigent has deteriorated dramatically in the last 13 years.

A special report issued by the Robert Wood Johnson Foundation claims that in the last four years, an estimated 1 million people attempted to obtain care, but couldn't afford it — and the *AMNews* recently pointed out that just as the proportion of Americans without health insurance has risen in recent years, the proportion of the poor and near-poor covered by Medicaid dropped during the same period.

Even still, Medicare and Medicaid paid a total of \$124 billion in benefits in 1986 — a figure that's likely to be even higher when figures for 1987 and 1988 are released — so, obviously,

some health care is being delivered. Exactly what *type* of health care is difficult to say.

The ills of the medically indigent seem to run both a physical and emotional gamut.

Physicians and health-care workers who regularly treat these patients talk about tuberculosis — a problem that seems to persist particularly among the homeless — of respiratory disease, scabies, pediculosis infestations, peripheral vascular disease and of such chronic illnesses as diabetes mellitus.

Medical professionals seem to be split on the amount of chronic alcoholism they see. In Massachusetts, reports indicate that chronic alcoholism accounts for barely a fifth of the problems treated in the homeless population each year — yet a recent study on the deaths among the homeless in Atlanta, Georgia, indicate that 70 percent or 28 of the 40 deaths studied were alcohol-related.

Mental illness, however, is by far the greatest health-care problem of today's homeless. The deinstitutionalization of numerous mentally ill patients at the beginning of this decade, coupled with the lack of community support systems to care for them, has created a nightmare on the streets.

“They are . . . unwelcome in the shelters because they are so

disruptive," says a California mental health worker in a recent issue of *Center* magazine. "You can't expect volunteers to handle someone who is abusive, drunk and schizophrenic all at the same time. That is a difficult combination even for professionals to deal with."

Yet, the problem, according to the American Psychiatric Association, is not the state of homelessness — but the mental illness. Sheltering these people is laudable, the association says, however, it doesn't take care of the basic problem — providing the chronically mentally ill with adequate access to psychiatric care.

The chronically mentally ill are not the only ones in need of psychiatric help, however. Homeless women, as has already been mentioned, suffer from personality disorders and emotional difficulties which inhibit their ability to lift themselves from their present situations, and their children are frequently depressed, talking often of suicide — some with serious intent.

Many of the physical and emotional problems of the homeless, as well as the rest of the medically indigent — might not seem as overwhelming as they do if proper preventive measures could be taken. It is the lack of regular preventive care that leads to the bigger, more expensive problems.

The patient's strep throat, for example, is treated more easily and more inexpensively in the early stage than the rheumatic fever or renal disease that may eventually develop.

Yet, as most experts in the field will tell you, there is no point in wishing that the medically indigent would come in for more frequent medical or emotional checkups. They won't.

Most ignore their problems or drown them in alcohol or drugs until it is too late to do anything about them. Those who do appear in clinics and hospital emergency rooms are generally unresponsive and noncompliant with orders.

As a result, medical professionals may feel frustrated and discouraged in their attempts to help these patients. Establishing a rapport requires flexibility, patience, persistence and the need for frequent outreach — difficult demands to make of the overworked physician. Sometimes, too, the doctor finds him or herself pushed into advocacy roles that are both time-consuming and unfamiliar.

Still, something needs to be done to help the medically indigent gain access to the health-care system.

There are, of course, plenty of options.

The method gaining the most attention, at this point, is the

legislation proposed by Senator Ted Kennedy (D-Mass) which would require employers to provide a minimum level of health-care benefits to employees.

Massachusetts recently became the first state to guarantee health insurance for all of its citizens . . . a point which arose naturally during the presidential campaigns . . . and both the American Academy of Family Physicians (AAFP) and the American Society of Internal Medicine (ASIM) have gone on record as supporting, if not Sen. Kennedy's specific proposal, then the idea of extended company-provided insurance.

"We applaud Sen. Kennedy's intent to expand availability of insurance coverage to a large population of Americans presently without it," says AAFP Executive Vice President Robert Graham, MD. The Academy expressed concerns, however, regarding the lack of preventive and health maintenance care for adults, although the proposal does mandate such care for children.

The ASIM has also stated that legislation requiring all employers to provide health-care coverage is the most viable option for insuring the employed because it would not only ensure that a majority of the uninsured would be covered, and eliminate much of the current cross-subsidization of health coverage,



“We see the disappearance of a blue-collar work force in America, people who used to get good-paying jobs that require a lot of skills.”

but also provide more appropriate coverage of high-risk individuals. In addition, it would place all employers under uniform insurance requirements.

However, many medical professionals have expressed concern about the viability of Sen. Kennedy's solutions to the problem.

But even if Sen. Kennedy's bill were to pass, what of the homeless?

If the homeless are ever to receive similar health-care benefits, it will be at the hands of state and local governments, where the responsibility of caring for the homeless has recently shifted.

Is such action possible? According to a poll conducted by the Intergovernment Health Policy Project, 43 states had targeted indigent care as a legislative priority in 1987, and additional states have contemplated bills this year.

While legislatures wrestle with the possibilities, the insurance industry has, in the meantime, come up with its own suggestions, including making more low-cost benefit plans available to employers, expanding Medicaid to those below the federal poverty level, encouraging the development of state risk pools and not-for-profit “reinsurance organizations,” as well as tax incentives to encourage employers to cover their employees.

The public, however, would prefer to see the federal government be the ultimate caretaker for the medically indigent. A poll, conducted by SRI Gallup, found that 37 percent of Americans believe the federal government should be held accountable for indigent care, while 15 percent responded “state”; 6 percent, “local”; and 4 percent, “all government.”

The federal government has been picking up a large portion of the indigent's health-care bills through its Medicare and Medicaid programs, and last year appropriated \$355 million for care of the homeless. Most of that money is gone now, and both Medicare and Medicaid funds are apt to evaporate just as quickly — especially as Americans grow older. After all, long-term care accounts for 43 percent of all Medicaid expenditures in this country, yet Medicaid, even now, serves only 40 percent of those Americans with incomes at or below the poverty line. As more and more demands are made for that money, more and more doubts are raised as to whether or not funds will be there for future needs.

While some alarmists are calling for universal health insurance, the American Medical Association has taken a low-key approach to the problem, calling, in an editorial

that ran in the *Journal of the American Medical Association* last year, for more physicians to become involved in caring for the medically indigent. Many already have, of course, including some here in Ohio, and that is the issue we'll be exploring next.

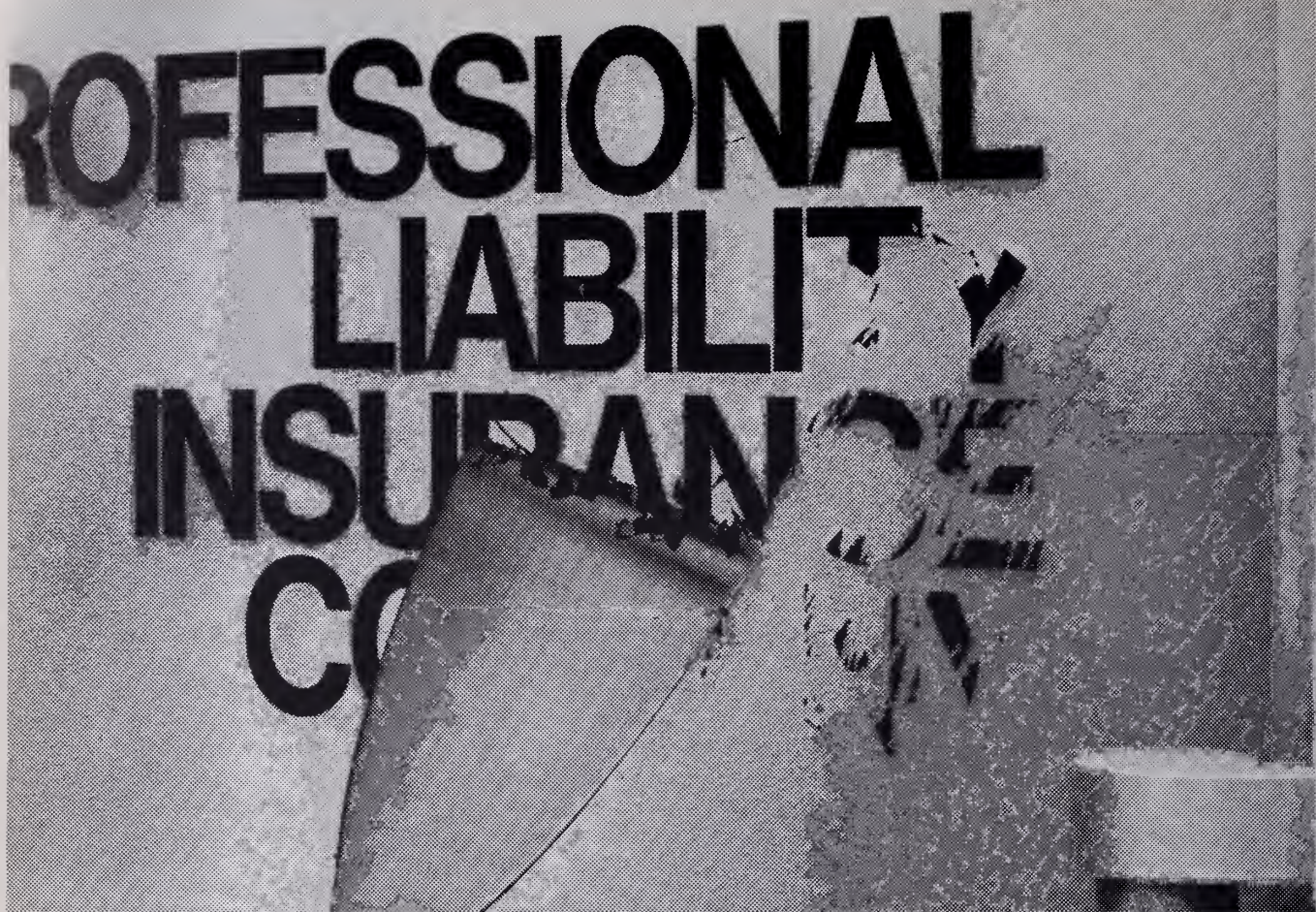
However, one can't help but ask the question, will such individual effort be enough?

One California social worker, quoted in an issue of *Center* magazine, sums it up best. He says:

“As much as we are trying to deal with the homeless on the local level, we're seeing a lot of disintegration in our society, particularly at the bottom social structures and strata. We see the disappearance of a blue-collar work force in America, people who used to get good-paying jobs that require a lot of skills. Those jobs are being taken away from them. Until something is done about that, until this country has a *full employment program* (everyone employed), we are trying to build a wall that just keeps leaking wherever you look.” **OSMA**

Karen S. Edwards is Executive Editor of OHIO Medicine.

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Does Medical Indigence Exist in Ohio?

By Karen S. Edwards

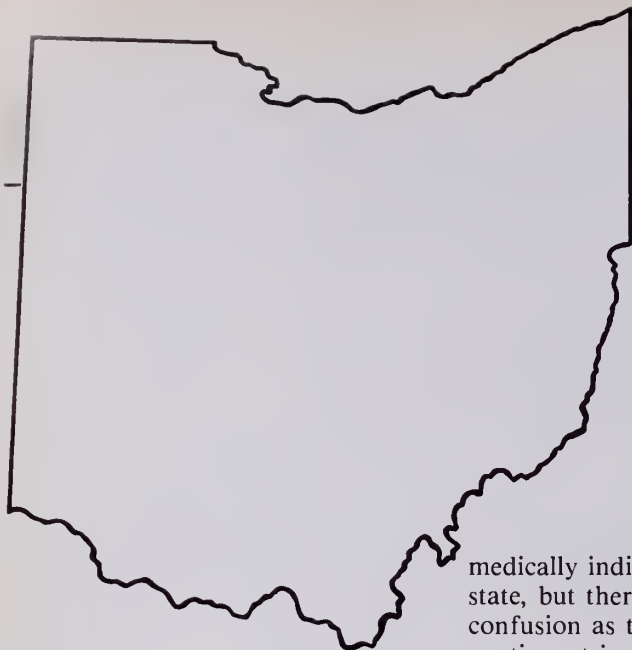
Ohio is a born mimic. Watch the national economy take a downswing, and Ohio soon follows suit with a dip in its own budget. If employment rates begin to rise across the county, so does Ohio's.

Does it naturally follow, then, that since medical indigency has

become a matter serious enough to be debated by the candidates during the recent presidential election campaign that it is a problem here in Ohio?

Much seems to depend on who you ask.

No one will quarrel with the fact that there is a contingent of



medically indigent patients in the state, but there appears to be some confusion as to just how large that contingent is.

During the early 1980s, when unemployment rates were sent unexpectedly soaring, there was little question that free or reduced-cost medical care was urgently needed by a large number of Ohio's population. Programs were immediately set up across the state to see that such care was provided.

Now, however, those programs have disappeared (see sidebar, "County Medical Society Programs: Missions Accomplished," for a more complete accounting), and some are saying that while there may still be a group of medically indigent patients out there, the size of the group has stabilized and their needs are being adequately met.

Of course, not everyone agrees.

"The problem of medical indigency in Ohio is a significant one," states Ronald Fletcher, MD, Director of the Ohio Department of Health — but he is willing to admit that the issue is a confusing one.

"The problem," he says, "is there is no hard data available which shows who the medically indigent are, or how many are out there."

Medicaid figures can roughly trace the boundaries of poverty in the state. Paul Offner, Deputy Director for Benefits Administration at the Ohio Department of Human Services, says that Medicaid currently pays out \$2.2 billion in benefits, which roughly serves a population of 1 million Ohioans at or below the

poverty level.

"Less than half of the indigent population in Ohio are eligible for Medicaid, however," he says.

Even those who might be eligible for state-assisted medical benefits often find the red-tape wrapping too cumbersome to cut through.

Bill Faith, who now serves as Director of the Ohio Coalition for the Homeless, but who has been involved with food programs and shelters for Ohio's homeless for the past six years, explains the reluctance of a number of Ohio's homeless to seek Medicaid benefits.

"You have to go through a lot to get hooked into the system, and many just don't bother. If you aren't paying for housing and you have no children, you would receive \$68 a month in Medicaid benefits, and \$68 is just not enough motivation," he says.

So, while Medicaid data can paint rather broad diameters of medical indigence in the state, it can, by no means, present the entire picture.

In fact, the figures miss entirely that half of the indigent population Offner alludes to, and which Dr. Fletcher describes in more detail.

"There is a growing population that may be attributed to the trends of change in unemployment," he says. These are the people who are falling between the cracks in the health-care system.

"The medical indigent are no longer unemployed," Dr. Fletcher continues, "but they are employed in businesses that provide little or no health-care benefits."

“We found that 25 percent of the homeless were employed — but in entry-level jobs where they were not receiving . . . medical benefits.”

He points specifically to the approximately 50 percent of the population that works in such “personal services” fields as the fast-food industry — an industry which continues to expand and develop, drawing employees from some of the large auto manufacturing plants which are phasing out, or otherwise withdrawing from Ohio.

“It used to be a kid would graduate from high school and join his dad or uncle at one of these plants and receive the same medical benefits they did. Now, the student is being lured by the fast-food chains which offer easy ‘ins’ and quick employment,” Dr. Fletcher comments.

And even still, the fast-food industry’s appetite for steady workers remains voracious. Now, as Dr. Fletcher points out, the industry is trying to lure the elderly to work.

“Yet this industry doesn’t provide hospital care for its employees,” he says.

So, suddenly, Ohio has an entire population living under what Dr. Fletcher describes as a double-edged sword — men and women who have found work and are, therefore, ineligible to receive any federal or state aid, but who are nevertheless without much in the way of health-care benefits.

Bill Faith describes a similar situation among Ohio’s homeless.

“In one study we did at the shelters, we found that 25 percent of the homeless were employed — but generally in entry-level jobs where they were not receiving the amount of money they needed to buy housing, nor were they receiving medical benefits.”

Like Dr. Fletcher, Faith also points to the changes in the economy as the reason.

“There has been a move away from industrialization to more white-collar jobs, so access to employment is now more limited,” he explains. “Then, all the new jobs in the last 10 years have been service-directed jobs, paid at the minimum wage.”

That makes it difficult for anyone entering the work force today to support him or herself, Faith continues.

“We see this all the time with students. Many of them are staying longer with mom and dad — at least those who are in the middle and upper classes where parents can afford to keep them. But those in poor or lower-class families don’t always have that option.”

As a result, both Dr. Fletcher and Faith agree that this new group of medically indigent is, by its very nature, a young group — often involving entire families.

“A number of today’s medically indigent are children or young people less than 24 years of age,” Dr. Fletcher says, while Faith adds that the age of the typical homeless male has dropped considerably in the past three or four years.

“In 1984-85, the Department of Mental Health conducted a study of the homeless in the state. At that time, the median age of the homeless male was 34 years. Now that age is less — about 29-30 years,” he says.

The Department of Mental Health study also failed to reveal many families living in homeless shelters — a fact that has also altered since the study was done,

says Faith. While he says the current data is far from scientific, “It’s our impression that there are more homeless families, women and children than there used to be,” he says.

“They are in that same situation where they are working, but they don’t have the \$8,000 to \$10,000 they need to obtain the medication they need.”

That’s why the Ohio Department of Health (ODH) is working with Ohio’s Department of Human Services to make AZT, the drug commonly prescribed in the treatment of AIDS, available to AIDS patients at cost.

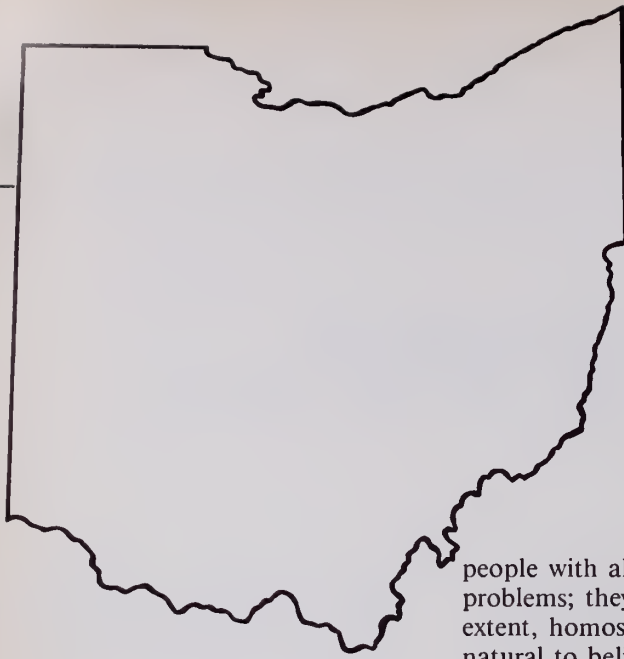
ODH is also working with the shelters to help them set up a policy on how to handle those homeless individuals who have AIDS.

Not all shelters will accept AIDS victims, reports Faith, but many do, and he predicts that eventually more will have to.

“We’re just beginning to see the problem show up now in the shelters, but I can see where, in the next 10 years, AIDS is going to be an even greater problem.”

AIDS victims, he explains, are especially susceptible to homeless situations because many of them lost their jobs, their medical benefits, and, frequently, their support systems. Residential homes capable of treating victims up to and through the last stage of the illness is the best solution to the problem, Faith says, but he has no false hopes that Ohio’s shelters can avoid the AIDS problems — even with the addition of more residential homes.

“Think about the homeless population,” he says. “They are



people with alcohol and drug problems; they are, to a large extent, homosexuals. It's only natural to believe this segment of the population is more susceptible to AIDS than other segments," he says.

Then what?

Faith isn't sure. Right now, AIDS patients are not isolated in shelters . . . "but we do see a lot more laundering and cleaning going on in the shelter when it's known that an AIDS victim is there," he says.

But the AIDS problem, and the subsequent indigent class that results, may yet need to be examined on a legislative level . . . an issue we'll explore in a moment.

First, however, it's worth noting that the one health problem that doesn't appear to be much of a problem here in Ohio is mental illness.

Since the deinstitutionalization of the mentally ill, it's easy to imagine that hordes of unstable individuals are showing up in clinics and shelters around the state, but Faith says it's simply not so.

"We aren't seeing a great many homeless with mental health problems," he comments, estimating that only about 30 percent of the homeless in Ohio's shelters have mental health problems (of course, not all shelters will accept mentally ill patients, either). Still, Faith attributes this success to significant improvements that have been made recently in the field of psychiatry. "They (psychiatrists) are now better able to control mental illness with medication," he says.

Programs, too, have been

specifically designed to help the mentally ill homeless. Project Liaison in Columbus, for example, provides that city's homeless with counseling services, while Tender Mercies in Cincinnati has set up a single-room occupancy shelter for those with mental health problems.

All of this is not to say, however, that emotional difficulties don't run rampant. They do, but Faith says it's more of a cause-and-effect type of situation.

"Frankly, I don't think I would last a week on the streets myself without experiencing some type of psychological problems."

Dr. Paul says, too, that a good many patients who show up with physical complaints at the Mt. Carmel clinic are actually suffering from emotional, "I-can't-cope-with-it" problems.

"They basically want someone to talk to," he says, which means those patients, usually older, have a tendency to overutilize the health-care system.

It's not utilization that concerns today's legislatures, so much as accessibility — and that's the issue that's being addressed at both the state and national level.

Our preceding article has already reviewed some of these proposed legislative solutions — i.e. Senator Kennedy's Universal Health bill and the newly-enacted Massachusetts program that mandates that employers must provide health-care benefits for workers.

Ohio's legislature, however, has also begun to delve into this problem, and is discussing solutions not dissimilar from those being broached in Washington.

"House Bill 927 is a carbon

“With the Dukakis model, we now have a perfect opportunity to see how the plan works without risking anything.”

copy of the Dukakis bill, without a few of the Massachusetts elements,” says John Van Doorn, OSMA’s Director of State Legislation.

The bill was introduced into the House by Rep. Robert Hagen (D-Youngstown), a railroad engineer. The bill, like the Dukakis program, is designed to provide health-care benefits for those who are employed but currently not receiving any health-care benefits from employers. Employers unwilling to pay a statutory minimum toward the cost of their employees’ health-care premiums would be taxed an amount commensurate to their employees’ premiums. A new state department would be created to see that Ohioans unable to obtain health insurance elsewhere could purchase private coverage through the program. The missing Massachusetts elements include hospital rate-setting and certificate of need.

Ohio does have some twists in its package, though. For example, under HB 927, universities must demonstrate that each college student is provided for under its health-care package — and each student must sign up or risk dismissal (unless he or she can prove coverage under a parent’s policy).

So far, OSMA has not taken a position on HB 927. It’s being supported in the House by the same consumers who support mandatory assignment and opposed, by and large, by the business community.

Van Doorn comments, however, that “What Massachusetts has found to be useful, the rest of the

country may not feel comfortable with.”

OSMA’s legislative staff, meanwhile, had other matters to attend to — specifically the hearings held by the House’s Health and Retirement Committee on what to do about Medicaid funding deficits.

Providers testified all summer long about the effect Medicaid cuts would have on quality care, and the OSMA testified at length on the lack of incentives — in fact, the disincentives — physicians have to participate in the Medicaid program. Not only has physician reimbursement from Medicaid been inadequate, the OSMA told the Committee, but many physicians are discouraged from treating Medicaid patients because of the tedious, time-consuming claims process.

The Medicaid issue, at this point, remains undecided.

Other matters being explored:

Risk pooling. House Bill 46 has already passed through the House, says Van Doorn, despite some privately expressed concerns about how it will be financed. The bill, which has stalled in the Senate, would use mostly state money to fund a “risk pool.” The pool’s reserves would be used to pay health-care costs for those employees who are considered bad health risks.

No one is willing to predict — yet — the outcome of any of this proposed legislation. Much will depend, to a certain extent, on the new administration that takes office in January.

Dr. Fletcher, however, advocates a wait-and-see position before any broad measures are taken in Ohio.

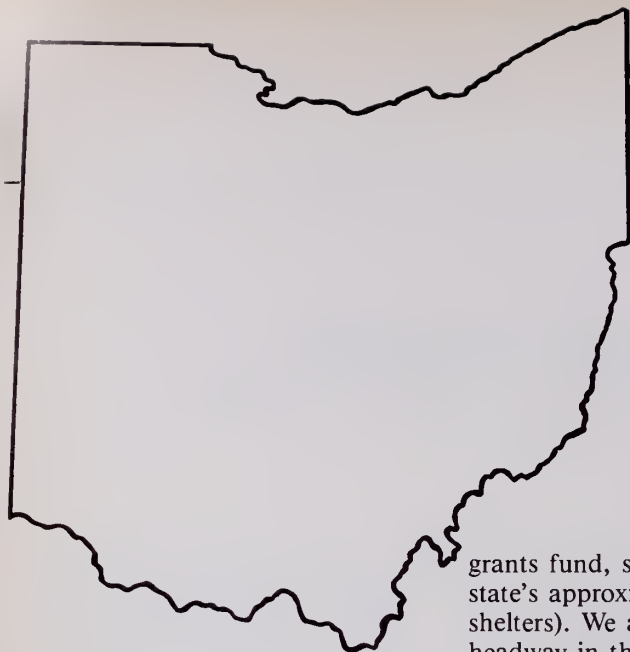
“With the Dukakis model in Massachusetts, we have a perfect opportunity to see how the plan works without risking anything. We may believe that it will work conceptually and philosophically — on paper it looks great — but does it work practically? At this point, it’s most prudent to take an interim approach, to make changes we can comfortably make now, without implementing the plan entirely.”

Of course, no plan has been made yet that takes care of everyone’s needs. There *are* additional steps that can be taken, however, says Dr. Fletcher, that may move us closer to that goal.

“We have to have the proper amount of correct data so that we can assess, correctly, what the situation is and make provisions accordingly,” he says. Correct facts and figures will enable the ODH, as well as other state and federal agencies to plan specific programs to meet specific needs. “But first we have to assess who has the needs — and what those needs are.”

Ask Bill Faith, and he’ll tell you that one of those needs is for more affordable housing. Homelessness is a direct result of a lack of affordable housing — and that is the problem, he says, that needs to be addressed.

“Speaking optimistically, legislative measures have been taken, and they are working,” says Faith. “Thanks to the McKinney Act, there is a federal program in place now (one of its provisions includes health care for the homeless), and we receive some support from the state government (the ODH, through a competitive



grants fund, supports 50 of the state's approximately 90-100 shelters). We are also making some headway in the private sector. But, if you look at the causes — the reasons for homelessness — then there are still big problems that need to be solved."

The McKinney Act, like most legislative measures, is only an interim measure — not a permanent solution to the problem. "That's why we're hesitant to help set up more shelters around the state. Yes, they're needed, but will they then become institutions, always there, like the poorhouses of old? Shelters are supposed to be a temporary solution to the problem."

The thought is, indigency and homelessness can become that transgenerational legacy we mentioned in our preceding article.

"The potential is there," says Faith. "On the East Coast, some families have spent three, five, eight years in welfare hotels. The children have grown up in essentially a homeless situation. The effects of this type of environment on children are bound to be dramatic. Studies are being done to determine the health effects on living in this kind of environment, and the psychological scarring that may result. How long-lasting will these effects be?" Faith asks.

Expanding government assistance (i.e. the Medicaid program) may help those in need of care — mental or physical — get it, says Dr. Fletcher.

He also suggests that medical education dollars be redirected to those areas where help is needed.

"We hear about the overabundance of physicians, but the overabundance is allocated to specific areas," Dr. Fletcher says. "There needs to be more of a balance in health-care manpower."

He points to risk-pooling and the federal government's catastrophic health bill as ways to provide more resources to the problem of uncompensated care, but like Faith, he refers to them as temporary measures at best. They don't *improve* the situation.

So, short of a windfall of new housing, and a new look at this country's social programs, is there anything that *can* be done?

Yes, says Dr. Fletcher — and some of those things can be done by you.

"Physicians need to get rid of their false assumptions," he says.

Those assumptions, for instance, that tell you a Medicaid patient is more likely to sue you than a paying patient.

"Where are the statistics to back that up?" he asks.

He also urges physicians to band together and agree to provide so much uncompensated care — again a type of burden-sharing that he says is working well in the Dayton area, and would work equally well with hospitals and medical schools.

"We also need physicians who can provide us with information," Dr. Fletcher continues. Such information can be the basis for the data bank that will help the ODH focus on specific plans and programs.

"Ultimately," he concludes, "physicians need to be aware that the growing medically indigent population is a *fact* and that it is

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“Physicians need to be aware that the medically indigent population is a fact . . .”

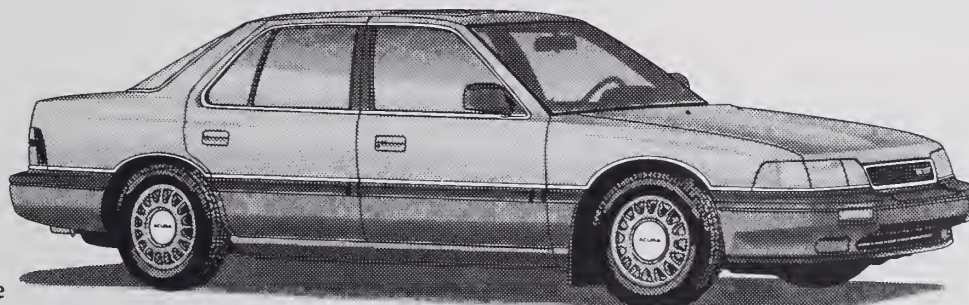
having an increasing socioeconomic impact on our state. We need to take a proactive stance to tackle the problem now — before it becomes much worse.”

OSMA

Editor's note: *Our next article reviews some of the proactive programs that are already in place here in Ohio.*

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Around-the-State Aid for the Medically Needy

By Deborah Athy and Michelle Carlson

According to recent estimates, nearly one in seven Ohio citizens lives in poverty. Unfortunately, a fact of life that often accompanies poverty is a lack of adequate medical care.

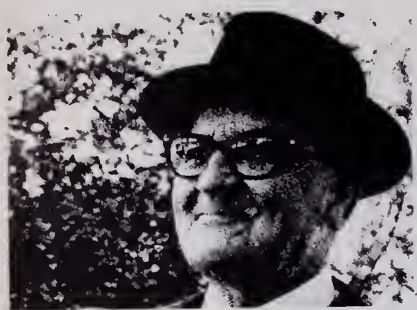
Programs around the state form a kind of piecemeal solution to the problem of inadequate health care, ranging from free clinics and volunteer physicians' services to health care on wheels and the modern-day Good Samaritan.

The programs might seem tantamount to a Band-Aid on a broken arm, considering the

disparity between the number of people in need and the amount of services available. But the programs represent, at the very least, a step in the right direction.

Lack of health care for the needy will probably continue to be a burden for many Americans and many Ohioans in the latter years of the 1980s and beyond — a boulder in the middle of the road toward the American dream.

Perhaps these programs and others like them will help to chip away at this obstacle, clearing the way for a healthier future.



OPENing up health care to the elderly . . .

When your average yearly income is at or below the poverty level, gaining access to health care isn't an option; it's next to impossible.

And when one considers that an estimated 25,000 elderly people — the largest consumers of health care — in the state of Ohio are living at or below the poverty level (\$5,360 per year for an individual, \$7,240 per year for a couple), one can surmise that a definite problem exists.

That's why in 1986 the Ohio State Medical Association, in conjunction with its component county medical societies, decided to launch Ohio Project Elderly Need (OPEN), a program under which physicians agree to accept Medicare reimbursement as full payment for medical services for patients who are 65 or older and who live at or below the poverty level. In instances where patients have no health insurance, the physicians have agreed to provide free care. However, the program covers only office visits, and does not extend to emergency treatment, hospital care or medications.

So far, 16 county societies have joined the program, and physician participation is estimated to be at least 70 percent (that figure will never reach 100 percent because some physicians provide services that either aren't covered by Medicare or aren't needed by elderly people).

For more information, call Bill Fry at the OSMA at (614) 486-2401.

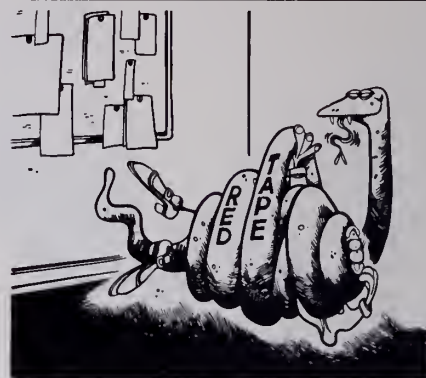
Taking care of business . . .

For Robin Bohnert of Hamilton, sorting through stacks of paperwork and yards of red tape is the nature of her company, the Professional Recovery Network, Inc.

She launched a pilot program in the fall of 1988 at Mercy Hospital of Hamilton/Fairfield to assist those individuals who lack medical insurance or who have been denied Medicaid.

The job entails filling out welfare forms, making phone calls, attending meetings and gathering documentation. In short, she epitomizes the aphorism, "If there's a will, there's a way."

Thus far she's recovered approximately \$200,000 to \$300,000 in unpaid bills for the hospital — bills that might have remained overdue without the recovery company.



Bohnert says the most difficult cases involve "the working poor," those who earn too much to qualify for Medicaid and too little to afford medical care.

With a 71 percent success record, it's not surprising that the hospital's business director called her a miracle worker. But it might not be miracle-working as much as it is perseverance.

In any case, the Professional Recovery Network, with its sleeves rolled up, is taking care of unfinished business.

North Coast Health Ministry . . .

Up on the North Coast — of Ohio, that is — four area churches have joined forces with local physicians to provide medical care for the indigent.

Staffed by volunteers, financed by area churches, and joined by physicians and other health-care providers, the North Coast Health Ministry offers medical and social services to residents in Avon Lake, Bay Village, Rocky River and Westlake.

The ministry began scheduling in November 1986, offering services on Mondays at their Lakewood office and Tuesday evenings at offices made available by St. John and West Shore Hospital. Several area hospitals also accept referrals from ministry physicians at no cost.

The ministry services does not handle pregnancies, birth control, venereal disease or substance abuse problems.



For more information, call (216) 228-7878, weekdays 9 a.m. to noon.

Health maintenance for the poor . . .

In Marion, Ohio, a program has been put in place to provide medical care for general relief recipients in a new way. It is the first area in Ohio to use an HMO for this purpose.

Those who qualify will have pre-paid coverage which should eliminate more costly emergency room visits and billing costs. All in all, the change is expected to save \$120,000 per year while increasing services to recipients.

As of January 1987, Marion is the only area in Ohio using an HMO for its general relief recipients. If this program is found to be successful, other counties may also follow suit.

Docs with a heart . . .

Valentine's Day is probably best known for candy hearts, red roses and sentimental cards, but physicians across the country are hoping to add to that image of caring.

By extending free medical care to poverty-stricken members of their communities on Valentine's Day, physicians nationwide are hoping to draw attention to the plight of the medically needy — those would-be patients who have either inadequate or no health insurance and/or no means to pay a physician's fee.

Started in Iowa in 1986, the program, which is called "Doctors With a Heart," quickly drew national interest, and last year, approximately 2,000 physicians participated in the program nationwide.

Physicians who would like to donate their time and services next Valentine's Day, or who would like to organize the event in their community, can call the national office at (319) 366-0698.



County medical society programs for the unemployed: missions accomplished

When unemployment in some areas of the state hit double digits in the early 1980s, many Ohioans found themselves out of work. A new population of uninsured and unemployed individuals was born out of the times — those who lost not just their jobs but their health benefits due to the economy.

The OSMA called attention to this program by adopting a resolution that sought "to encourage the development of an effort to provide free or reduced cost health care to those of our neighbors who currently are unemployed, uninsured and ineligible for Medicaid or other existing assistance programs."

County medical societies around the state responded by developing programs that provided temporary health-care services and hope for this new group of uninsured Ohioans.

The *OSMA Journal* reported on the progress of these programs in November 1983. Five years later, *OHIO Medicine* takes a look back, asking "Whatever happened to Academy Med-Assist, Project Mend and Project Health Concern?"

After a series of calls around the state, the verdict was in. For the most part, the programs have been gradually phased out after serving their purpose during the years of economic distress in the state.

Many of the county medical societies say that services are still available for individuals who can demonstrate need. But the need for temporary health services for the unemployed has largely leveled off.

George Reitz, Executive Vice President of the Academy of Medicine of Cleveland, says that Project '83 — the uninsured

program for the Cleveland area — was very effective at the time. "Over the life of the program, 1,500 physicians were involved, and more than 4,000 individuals were serviced," he points out. But now that the phones have stopped ringing, Project '83 has been discontinued.

During the early 1980s, the need for this type of program was apparent, agrees Richard Tapia, Executive Director of the Montgomery County Medical Society in Dayton. But as the traffic in the program began to slow, Project Mend was gradually phased out.

Project Health Concern in Columbus has been transferred to call-back services because it was generating only one call a month, according to Carol Edgar of the Academy of Medicine of Columbus and Franklin County. The switch conforms to the original concept of the program as a one-year, temporary endeavor. But medical assistance is still available in the Columbus area, she says. "A lot of physicians will take someone without insurance on a one-time basis."

Managing Director Shirley Bee of Summit County Medical Society says the society maintains an active referral file, but Project Summit — Akron's version of the uninsured program — has been filed away.

And other programs, such as Academy Med-Assist in Toledo, have not been discontinued per se, but they are not very active these days.

Overall, the programs of the early '80s have been phased out along with the years themselves. Perhaps some of their inspiration lives on in current programs such as Ohio Project Elderly Needy (OPEN). — *Deborah Athy*



Charles Dillard, MD

A modern-day Good Samaritan . . .

He's been described as a living legend in an article in the *Cincinnati Post* . . . recognized by the American Medical Association . . . featured in a photo exhibit called "Portraits of Excellence."

The accolades are impressive. But perhaps what is more impressive about Charles Dillard, MD, an internist from Walnut Hills, is that he demonstrates a truth that is often lost sight of: *One person can make a difference.*

His career has hinged on helping those in need, from the inner-city patients of Cincinnati to the famine victims of Sudan and Ethiopia.

In 1985, Dr. Dillard helped to form Cincinnati Reaches Out, a missionary group that collected medical equipment and medicine

for famine victims. The group collected donations to build a medical clinic in Sudan.

Back in Ohio, Dr. Dillard established the Walnut Hills-Evanston Medical Center, a program that combined paying and non-paying patients with the rationale that the profits could be used to support the medically needy.

Dr. Dillard is learning more about the health-care needs of Third World nations in a special National Guard program. Not surprisingly, he plans to put the information to practical use during trips to Haiti and Honduras.

Dr. Dillard has earned acclaim for his work in Cincinnati and in more remote locales. But in the final analysis, his actions speak louder than words.

Securing high-priced AZT for AIDS patients . . .

If asked, most of us would agree that money is no object where prolonging one's life or the life of a loved one is concerned.

But suppose that the cost of prolonging that life totaled thousands of dollars each year — *for the prescription medication alone.* And suppose that the patient had no or inadequate health insurance, couldn't qualify for public assistance (Medicare/Medicaid), and was unable to work because of the debilitating effects of his or her disease? How would he or she *ever* be able to afford the medication?

That's precisely the situation that many AIDS patients across the country are finding themselves in as they try to secure quantities of the AIDS-fighting drug, AZT. The drug, which is called Retrovir by its manufacturer, Burroughs Wellcome Co., not only prolongs the lives of AIDS patients by inhibiting the reproduction of HIV, the virus that causes AIDS, but it

also relieves patients' physical discomfort.

But while obtaining a prescription for AZT is relatively easy, affording the high-priced drug is anything but.

Fortunately, the federal government has acknowledged the urgency of the situation, and last year it allotted the state of Ohio a one-time grant of \$293,777 to help defer the cost of supplying Ohio AIDS patients with AZT.

The program, which requires individual patients to earn \$1,020 or less per month to become eligible (that figure is slightly higher for married patients and those with dependents) is apparently working: As of September, about 150 Ohioans were eligible to receive the drug for as little as \$2,055 to \$3,082 a year, depending on how many tablets they take each day. Of those, about 95 participated in the program, with almost half eventually becoming eligible for



Medicaid.

Although the state originally thought that the grant would run out on Sept. 30 and any leftover funds be returned to the federal government, federal officials have indicated they don't want the money back. Since learning of the decision, the state has set up a direct-mail system through which AIDS patients who qualify for the program can continue to receive AZT.

And that's news for which at least some Ohioans can be thankful.



Classroom contributions

A program at Youngstown State University has been launched in response to the growing population of Ohio indigent. Funded by a two-year grant, the Multidisciplinary Outreach Curriculum Focused on Health-Care Needs of the Poor is a program that should expand the curriculum of upper-level health profession students. Youngstown faculty in dental care, nursing, medicine and nutrition will assess — and expand where warranted — their current curriculum in regard to the philosophical, ethical, economic, political and health aspects of the poor.

The second year of the grant calls for the development of clinical education sites and multidiscipline medical seminars to further focus on aspects of health care for the poor.

Help for the homeless...



Cleveland is one of 12 U.S. cities to receive a grant from the National Institute of Mental Health (NIMH) to ease the double burden of mental illness in the homeless. The two-year grant will fund community-based programs such as mental health services, housing assistance and crisis counseling.

According to NIMH Director Lewis Judd, MD, the profile of the typical homeless person is no longer a middle-aged alcoholic male. In some areas, a large percentage of the homeless is now composed of women, family groups and children — many of whom are emotionally disturbed.

“For some people, mental health problems are a contributing cause of homelessness, and for others they are a consequence of homelessness,” says Dr. Judd. “In either case, the need for more and better services for these people grows daily.”

Other cities receiving similar grants include New York, Washington D.C., Chicago and Portland, Oregon.

For more information, contact Debra Rog, Program for the Homeless Mentally Ill, NIMH, Room 11C25, 5600 Fishers Lane, Rockville, MD 20857, (301) 443-3706.

Taking health care to the streets . . .

For most homeless people, finding that next meal or a place to stay for the night is usually of the utmost concern, so it's not surprising that a few of them have little time to consider the state of their health.

But thanks to the generosity of a number of Greater Cincinnatians, a mobile health-care clinic — actually, a medically-equipped van — has been dispatched to serve the medical needs of that city's homeless.

The clinic-on-wheels, which was first launched last May, parks one night a week in front of the Mary

Magdalene House in Over-the-Rhine and offers free examinations and minor medical treatment to homeless men, women and children. Patients who require more extensive treatment are referred to the city's Elm Street clinic or University Hospital.

As mentioned, a number of people contributed to the effort, including the volunteer Cincinnati Health Network, which sponsors the program; the Health Initiative fund-raising group, which pledged \$40,000; the Cincinnati Academy of Medicine, which promised volunteer physicians to staff the



van; and the city health department, which donated the van.



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\$ 200,000



Medical Specialty:

Obstetrics/
Gynecology

Radiology

Neurosurgery

General Surgery

General Surgery



Verdict:

For the defendant

For the defendant

For the defendant

For the defendant

For the defendant

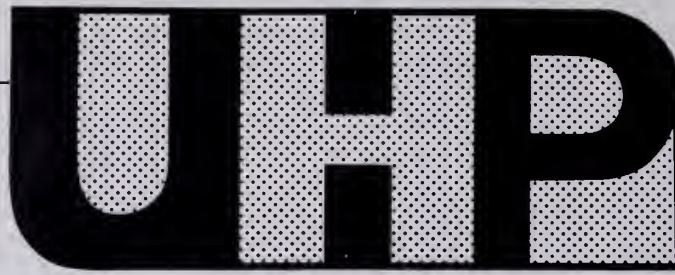
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URBAN HEALTH PROJECT

The Medically Needy — and the Next Generation

By Ross D. Martin

What's wrong with medical education today?"

The question prompts strong opinions, frustration and at times heated debate. The challenge of training competent and caring physicians has become increasingly difficult in a society hallmarked by rapid change. Many assert that the future physician will be less able to relate to patients on a human level because of the barrier produced by expanding technology. In the presence of a significant socioeconomic and cultural disparity between caregiver and recipient, the physician's ability to provide relevant treatment and the patient's ability to comply may be impaired even more.

Medical schools are faced with a dilemma. The minimum proficiency required of the graduating medical student grows exponentially with each new journal published. Areas of study which did not even exist 50 years ago now demand prime classroom coverage. At the same time, the increasing sophistication of medical knowledge produces a climate in which it becomes more important than ever for the physician to relate to his or her patient on a mutual level. This task is especially difficult when the individual seeking treatment comes from a low socioeconomic or educational background.

In spite of these increasing demands, students are required to

file through medical school in the same four years as always. Curriculum committees struggle to find new ways to slice and distribute the same time pie. A smaller and smaller portion can be spared for educating future physicians as to the special conditions surrounding the medically underserved. Clearly, the need for this crucial education cannot be overlooked.

In at least one instance, the impetus for addressing this need did not come from the upper echelons of a medical school administration but from the students themselves.

At the University of Cincinnati College of Medicine, students have conceived and developed a



UHP intern Teresa Quaintance gives basic first aid instruction to mentally ill senior citizens at the Salvation Army Adult Day Care Center.



Tamara Whitaker compiled a detailed listing of accessible housing.



Cincinnati's homeless are a few of the recipients receiving care under the Urban Health Project.

continued on page 963

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program called the Urban Health Project (UHP) in an attempt to educate themselves about the underserved. The primary component of the UHP is a summer internship program in which first-year medical students from the University of Cincinnati are placed in area social service agencies for nine weeks. These agencies are chosen because they work with those who typically receive inadequate care from the medical community—the poor, the homeless, the elderly, the disabled, the mentally ill, the minority.

Depending upon the agency, the interns perform a variety of services. Some work as educators and counselors; others take on special research projects or serve as regular staff members. One student serves as director of the program for one year, raising support for the program and addressing administrative concerns.

The agencies, which are usually desperately understaffed and underfunded, pay nothing for the intern; the UHP provides a stipend to each intern which is comparable to the pay received by a research assistant at the university. Besides a stipend, the interns receive an education which cannot be duplicated in the classroom; working with the underserved in a non-clinical setting gives the students first-hand experience in dealing with health problems which cannot be handled by simple prescription. The students further enhance their learning by meeting together each week to share experiences.

Jeanne Corwin, one of the UHP interns, worked at the Urban Appalachian Council this summer. She helped run a six-week "Earn and Learn" program sponsored by the Cincinnati Youth Collaborative. The program focuses on 13- and 14-year-olds who are at high risk of dropping out of school. Corwin



Ted Schoettinger dispenses medication at a residence facility for the homeless mentally ill.

worked with Appalachian youth each day, designing community service projects and learning programs to enhance reading, writing and communication skills. The kids were paid for their participation. Corwin found the experience rewarding and enlightening, for although she grew up in Cincinnati, she knew little about urban Appalachians who make up a sizeable portion of the city's population.

Many are from low income households or broken homes. Most of them don't know many people who have actually graduated from high school. Most of them *do* know what physical, alcohol and drug abuse are."

Corwin continued, "Seeing all this, the term 'poverty cycle' begins to make a lot more sense to me. Growing up in this kind of environment, these kids don't know how to live their life any

"Seeing all this . . . the term 'poverty cycle' begins to make a lot more sense to me."

"I was able to see how growing up in not-so-ideal conditions affects every aspect of a child's life," she says, "whether that be their school work, their behavior or their future. All of these kids have their own set of problems.

other way. They don't know how to take advantage of the educational and economic opportunities that the United States so prides itself on. They don't know how because it is a life foreign to them. There is a real

lack of role models. I also feel that not only do they often not know how to be a success, they believe it is something not available to them . . . not within their reach. These children are too often born into a life where everything is against them. To overcome this is a monumental achievement.

"I'll probably never know," she concluded, "if our program made a difference in any of their lives, but I learned so much and I understand so much more about how people live and the problems they face. What I learned has changed me and will definitely shape my career as a physician. I will never forget."

Ted Schoettinger had a very different experience working at Tender Mercies, but he learned similar lessons. Tender Mercies is a non-profit organization that provides low-cost permanent housing for homeless individuals who are mentally ill. Schoettinger recounts one lesson from his experience, saying, "A particular time of sadness during my internship came when Leonard, one of my favorite residents, died of pneumonia. Though he seemed older than his 58 years, Leonard was childlike in the simplicity of his ways, yet he valued his independence. A favorite expression of his was: 'I'm a human being too, you know.' That statement nicely sums up the importance of the mission of Tender Mercies. Just because I was lucky enough to be born into an environment full of enriching opportunities and loving support does not make me any better than one of our residents who, for whatever reason, is burdened by mental illness, poverty or lack of family support. In fact, it is the duty of those of us who have to help out those of us who have not. The reason? Leonard and the

others have taught me that it is simply because we are all human beings put in this world to live together."

Reflecting on the experience as a whole, Schoettinger says, "As a future physician, I have gained an invaluable experience at Tender Mercies. Medically, I have had an excellent clinical exposure to a variety of mental illnesses. In terms of my overall education, I have learned much about low income housing, the welfare system and the vast network of social service agencies. I have raised my political awareness on the issues

Alice Paul House and Bethany House, shelters for battered and homeless women; Lighthouse Runaway Shelter, an emergency home for troubled youths; Total Living Concepts, Inc., a non-profit agency providing independent living assistance for persons with disabilities; St. John Social Service Center, a community center for the elderly in one of Cincinnati's low-income neighborhoods; Salvation Army Adult Day-Care Center, a program for elderly persons suffering from mental illnesses; and the Cincinnati Health Department Lead Poisoning

"This lesson has been taught to me by teachers who do not have degrees or comfortable salaries."

surrounding the homeless. But my most valuable lesson has not come from the psychiatrists, the administrative staff or the social workers who surround me at Tender Mercies. This lesson, rather, has been taught to me by teachers who do not have degrees or comfortable salaries and who are not famous or widely acclaimed. This lesson is basic human dignity so proudly illustrated by our residents at Tender Mercies."

Tender Mercies and the Urban Appalachian Council are only two of the 10 placement sites served by the UHP. A summer intern was also placed at the Social Health Association, where the intern did research on AIDS education for elementary and high school students. This intern is given the special responsibility of continuing the medical school's AIDS education program at the Cincinnati Juvenile Detention Center and area runaway shelters.

Other agencies participating in the summer program included

Prevention Program.

The UHP has taken a very visible role at the University of Cincinnati College of Medicine. Since its conception in 1986, the number of applicants to the program has far exceeded the number of positions available. During the subsequent academic year, the students who participated in the summer program hold lunchtime seminars which serve to inform other interested students about their experiences. In addition, a spring seminar on "Medical Care for the Underserved" is planned and executed by the interns.

Funding for the UHP comes from several sources. The program has enjoyed strong support from the dean's office at the College of Medicine, through monetary grants and in-kind support. Community support has been provided by the Anderson Foundation, the Greater Cincinnati Foundation and Christ Episcopal Church. The growth of the UHP has been hindered only

by budgetary constraints. The students hope to raise support soon for the next three years so that they may concentrate future fund-raising efforts on seeking an endowment for the program.

Additional information concerning the program may be directed to:

Ross D. Martin, Director
Urban Health Project
University of Cincinnati
College of Medicine

231 Bethesda Avenue
Cincinnati, OH 45267-0552
(513) 558-5990

Ross D. Martin is a second-year student at the University of Cincinnati College of Medicine and is currently serving as Director for the Urban Health Project.

Editor's note: Next month, the Medical Student page will return to this space.

Next month
in

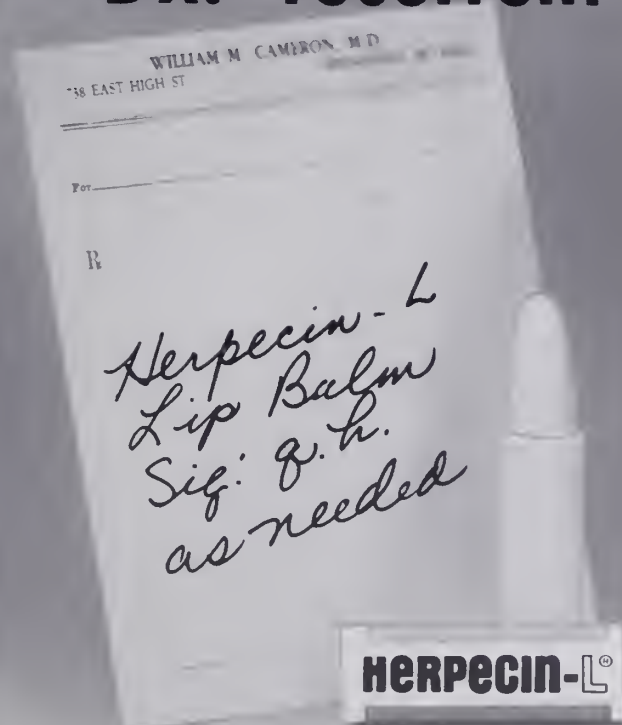
OHIO Medicine

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The Legislative Review

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The Dermatology Annual Meeting

Editor's note: OHIO Medicine will periodically present glimpses of specialty society meetings as they are held. To initiate the column, OHIO Medicine visited with the dermatologists at their 5th Annual Meeting in Cincinnati.

The fifth annual meeting of the Ohio Dermatological Association was held in mid-September at the Cincinnati Westin hotel in Cincinnati. Topics discussed included Retin-A and its effect on aging skin, generalized granuloma annulare in AIDS patients, and what's new in dermatology. Malcolm Greaves, MD, a British physician, presented this year's Belcher Memorial Lecture on "A Novel Anti-Aging Preparation — Science or Fad?"

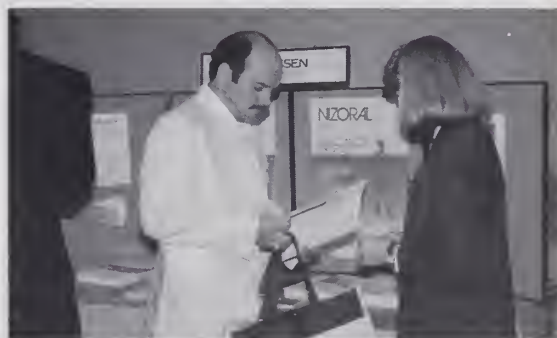
Participants in the Fifth Annual Meeting of the Ohio Dermatological Association attended seminars on various topics, ranging from "IgA Pemphigus Foliaceus" to "The Retin-A Story."



Exhibits are a popular stop at the Annual Meeting.



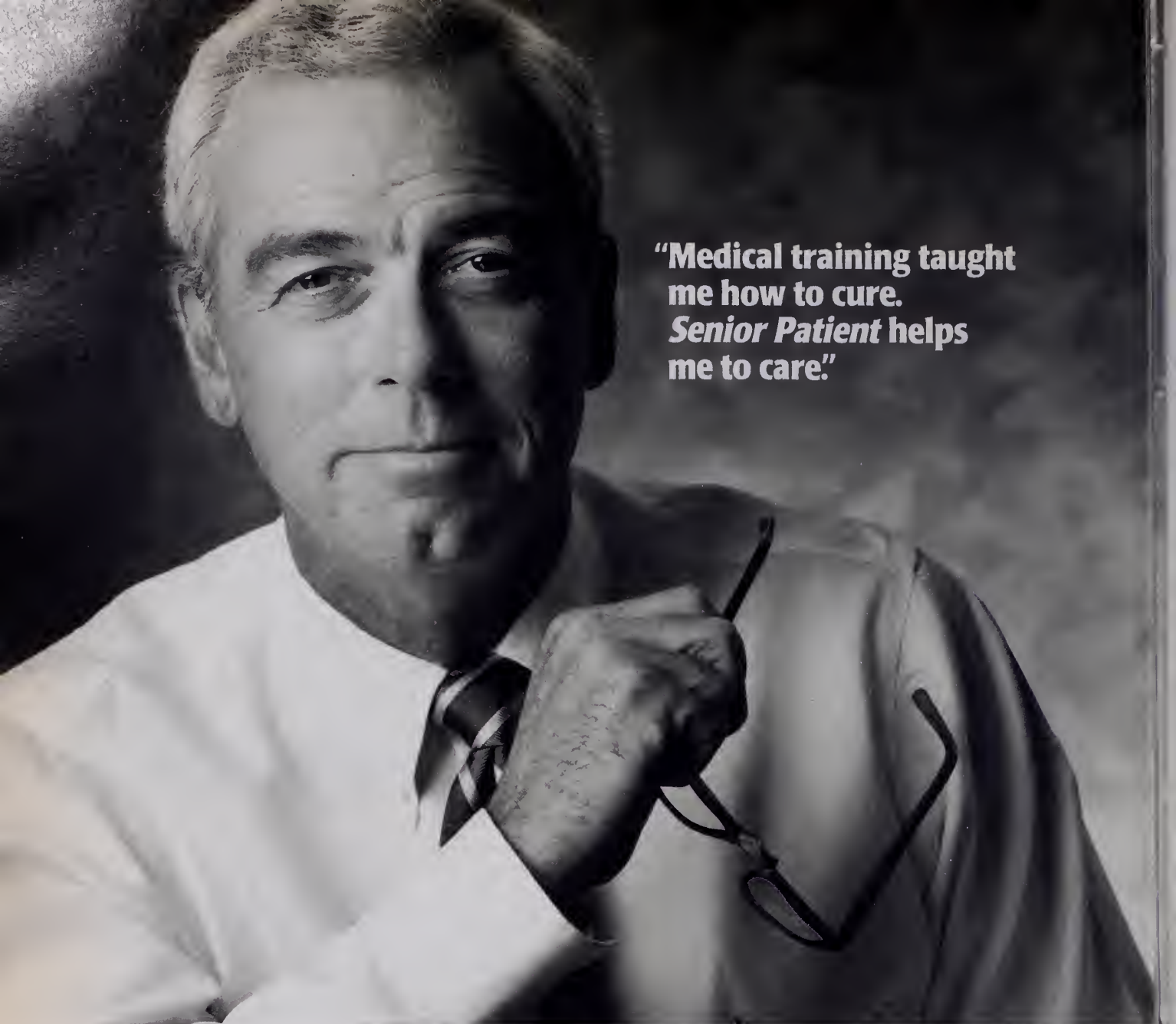
The Annual Meeting is a place to exchange views and opinions on the rapidly-changing practice of dermatology.



James Mars, MD (left) and seminar speaker Malcolm Greaves, MD take in some of the latest information.



continued on page 969



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Malcolm Greaves, MD, of London, England, presented the Belcher Memorial Lectureship.



"A Novel Anti-Aging Preparation — Science or Fad?" Malcolm Greaves, MD, reveals the answer . . .

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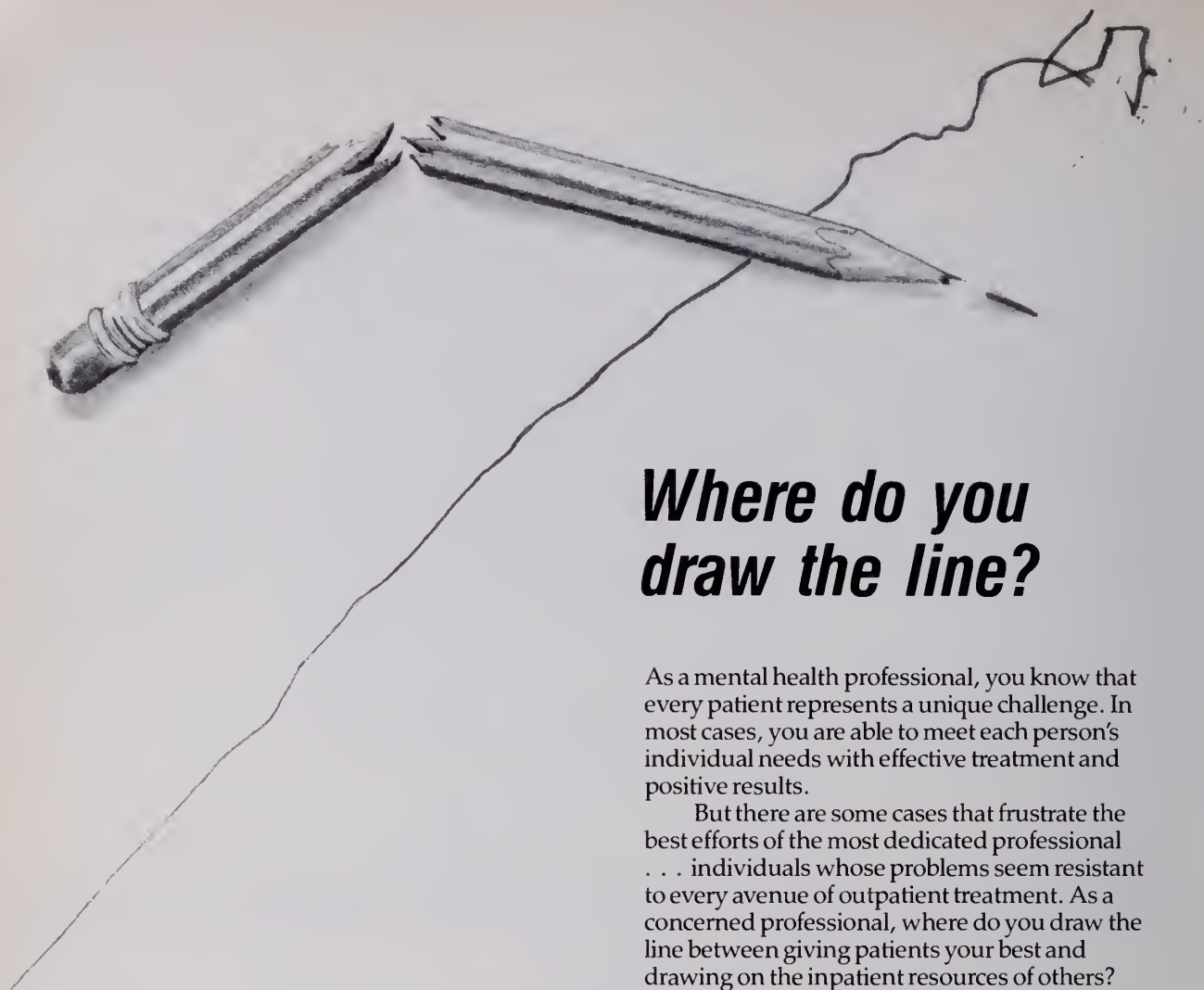
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Referrals and Consultations: Avoiding the Risk of Liability

Claims statistics show that physicians can become involved in malpractice claims because they attempted to handle a condition beyond the scope of their training or experience.

Doctors who are deeply immersed in primary care without specialized clinical skills training often recognize that they are at tremendous risk — but in attempting to provide immediate patient services may become compromised. Also at risk are physicians who do not have a strong referral network; doctors without frequent contact with hospital staff activities; and doctors who do not have adequate arrangements for cross coverage, which at times are challenges faced by those in local areas.

The Need for Referrals

General practitioners who treat conditions and who perform procedures usually done by specialists are held to the same standard of care as the specialist. This makes it unwise to treat a condition or perform a procedure at a specialist level when the

physician is not a specialist.

Why Refer?

From a clinical standpoint, it is advisable to refer a patient to a specialist if the diagnosis remains unclear or the methods of treatment have been ineffectual. Similarly, if the required care is more appropriately handled by a specialist — or if other therapy may be more beneficial — then the patient should be referred.

The following recommendations can lessen the risk of liability in referrals:

- If time is essential to avoid permanent damage or to minimize the seriousness of a problem, emphasize this to the patient; it also is important to call the consultant to assure that the patient is seen promptly.
- When making the referral, clearly communicate the reason to the consultant and define the scope. Clearly indicate who is managing what aspect of the case. If you will continue to manage some aspect while the specialist is concurrently treating the patient, both doctors need to understand this.

- Coordinate and correlate all orders — particularly prescriptions — with those the consultant may write.
- If you have requested a second opinion or a diagnostic consultation from a specialist and then decide to proceed with treatment different from that recommended by the specialist, document the patient's chart with the reasons why you have chosen not to follow the specialist's advice.

Requests for consultation preferably should be in written form, with a copy filed in the patient's chart. If later questions arise regarding the scope of the consultant's care, something other than memory of a telephone conversation will exist for clarification and documentation.

Protection for Consultants

For physicians in a consulting role, there are some recommendations that can help minimize the risks of liability for referrals.

- You have the duty to try to see the patient as quickly as possible, particularly for a

Loss Awareness . . . continued

condition where successful outcome depends upon prompt treatment.

- You should have clear instructions and understanding about which aspects of the case you will manage.
- You will need to keep the referring physician informed about the patient's care. If you have been asked for a diagnostic opinion, any verbal diagnosis should be followed with a written report to the referring doctor.
- If you are treating a patient on referral who you think has not had the best medical care, it is important not to criticize the referring physician's care to the patient. Malpractice claims often result from the criticism of a consulting physician.

The Loss Awareness Bulletin is provided each month through the OSMA's Task Force on Professional Liability and its subcommittee on Loss Awareness.

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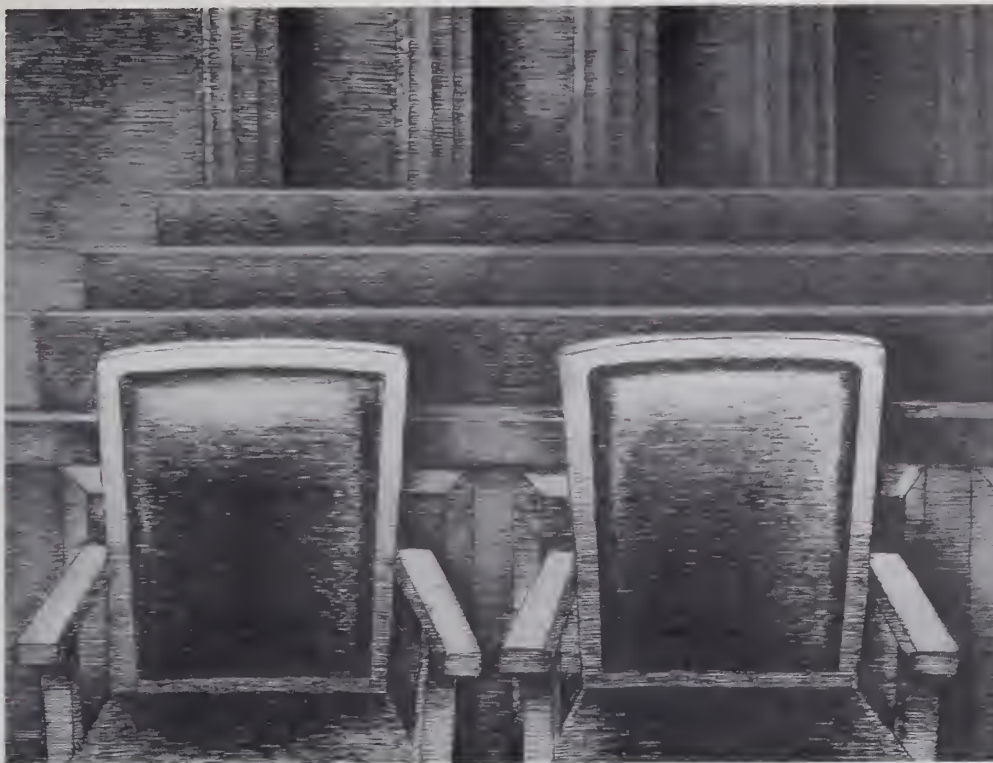


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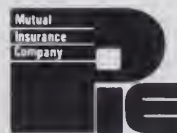
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Up to His Old Tricks

Mansfield physician rediscovers love of magic

By Michelle J. Carlson

When Dr. Keith Bogart's wife Alice requested that he "do something" with two sealed boxes that had laid around their house for years, he had no way of knowing that a long-lost hobby was about to be resurrected.

The boxes, you see, were labeled "Magic," and contained the long-abandoned relics of a young boy's passion for magic tricks. That was six years ago, and to hear Dr. Bogart tell it, by opening them, "I literally opened Pandora's Box, and now I'm possessed by it."

Today, the Mansfield neurologist not only entertains various organizations with his magic act, but his once-modest collection of magic tricks has grown so much that Dr. Bogart now owns "two full rooms and a basement full of (magic) stuff," he says with a laugh.

A passing interest

The itch to learn magic, Dr. Bogart recalls, struck when he was just 10 years old. "My interest was triggered by someone selling magic tricks at the Sandusky County Fair," he explains. "I bought a few tricks and started to read a lot" about magic.

But like most youthful interests, the hobby was relatively short-lived, and the magic tricks were relegated to storage for nearly 30 years. Until that fateful day six years ago, that is.

Since then, Dr. Bogart's magic act has become so popular that he regularly performs about 25 to 30 times a year for various benefits and community and business organizations.

"I do get paid," he says, "but it doesn't supplement my income very much," which is understandable when one considers that each trick can cost anywhere from \$30 to \$500, or that he uses about \$4,000 to \$5,000 worth of props and equipment for each show.

"I really do it more for the enjoyment," he continues. "Magic is a performance hobby, and if you don't do it for the public, it's pointless."

Tricks of the trade

Dr. Bogart's act, which he terms "cabaret" or "nightclub" magic, generally lasts from 30 to 40 minutes and incorporates a fair amount of humor as opposed to spectacular stunts.

"The fun of it is the patter that

goes along with it," he says of his show. "(My act) is sort of a spoof on magic . . . the idea is that this is a magician where not everything goes as he expects."

Dr. Bogart generally begins his act with a fiery trick — "something like turning torches into canes, something flashy," he says — then progresses to "a silly sort of trick with plays on words." Also included are assorted card tricks and a guillotine trick in which his 10-year-old son sometimes participates. ("He loves to get his head cut off," Dr. Bogart jokes.)

The show usually ends with "Too many bottles," a trick in which every time the magician manipulates two hollow tubes, yet another bottle appears. The trick, in keeping with his act, is not as spectacular as it is humorous. It is also, he says, a favorite among audiences.

"It's almost become my trademark," Dr. Bogart says. "If I don't do it, people always come up afterwards and ask, 'What happened to the bottles?'"

Although his act does not include any grand acts of illusion — a la Doug Henning — it's not because of a lack of skill. "I

rarely do illusion tricks because I work alone," he explains. Also, "The big things really require that you have a large stage," and most of the venues he appears in are simply too small.

The art of juggling

Not surprisingly, Dr. Bogart's interest in magic doesn't stop with his act. Not only is he past president of the Knights of Magic and local representative of the International Brotherhood of Magicians, but he was also recently inducted as an associate member of the Inner Magic Circle of the elite, London-based Magic Circle.

Of the latter, which is an invitation-only association of professional magicians, Dr. Bogart says, "That was a high honor . . . I was very pleased."

When one considers that in addition to all of the aforementioned commitments that Dr. Bogart is also current president of the Richland County Medical Society, one might be tempted to say that he should be a juggler, not a magician.

Just how does he find time to brush up on his act?

"I might run through it a day or two before (a performance)," he says, "(but) since it's a standard act, I can usually just get up and perform it."

When he is feeling a little rusty, laughs Dr. Bogart, "If I have about 15 minutes before patients, I'll pull out a deck of cards and practice some sleight of hand."

Michelle Carlson is Editorial Assistant for OHIO Medicine.



Physician-magician Keith Bogart, MD, practices some sleight of hand (above and left)

VERY LOW-BIRTH WEIGHT INFANTS: FIVE YEARS EXPERIENCE OF A REGIONAL PERINATAL PROGRAM

Leandro Cordero, MD
Frederick P. Zuspan, MD

Perinatal Region IV comprises 33 counties of central and southeast Ohio. Maternity services are provided at one Level III, four Level II and 28 Level I hospitals. Linked birth and death certificates were used to determine neonatal mortality (NM) of 1,160 very low-birth weight (VLBW) infants born during 1979-83. VLBW deliveries increased (2.7% to 3.2%) at Level III, remained unchanged at Level II (1.1%), and decreased (0.6% to 0.4%) at Level I hospitals. NM (<28 days) was 36% at Level III, 52% at Level II, and 55% at Level I, and mortality for the first day of life was 22%, 38% and 51% respectively. All these differences were statistically significant. Shifts in place of birth for VLBW infants and lower NM at Level III highlight the success of regionalization of perinatal care. High first-day mortality at Level I and II underscores critical differences in intrapartum and newborn care and reiterates the importance of place of birth on survival of the VLBW infant.

Leandro Cordero, MD, is a professor of pediatrics and obstetrics in the College of Medicine at The Ohio State University; Frederick P. Zuspan, MD, is a Richard L. Melling professor of obstetrics and gynecology at the same institution.

Introduction

Every pregnant woman and her infant should receive care at a level appropriate to their needs. This can be accomplished by maternal referrals and/or transport which will result in a shift in the place of birth. National and state guidelines published in the late '70s¹ divided Ohio into six perinatal regions, classifying maternity units according to their level of care (I, II or III). The outcome of specific high-risk groups such as VLBW infants has only recently been used as a measure of success for regional perinatal programs.²⁻⁵

This manuscript deals with the five-year experience of a regional perinatal program in a defined geographic area using the outcome of VLBW infants as a marker of success (1979-1983).

Study Population

Perinatal Region IV serves 33 counties of central and southeast Ohio where 2.3 million people live and approximately 35,000 live births occur every year. One-half of these deliveries take place in the urban county (Franklin) where the Level III maternity hospital designated as the Regional Perinatal Center (RPC) is located. Five community hospitals (one Level I and four Level II) are located in the same urban county and 27 Level I maternity hospitals, dispersed throughout the region, serve the rural population. Twenty-six percent of VLBW infants delivered at the urban county. This geographic area is the largest area of a perinatal region in Ohio.

Methods

Linked birth and death certificate data obtained from the Ohio Department of Health provided information regarding hos-

pital of birth, time and cause of death, sex, race, plurality, birth-weight and gestational age. Infants whose birth weight was less than 500 gms and those whose primary cause of death was congenital malformations were excluded from the study. VLBW infants were those born alive with birth weight ranging from 500 to 1,250 gms. Log linear analysis of three-way frequency tables and Chi-square were the statistical methods employed.

Results

Preliminary comparison of neonatal mortality rates for VLBW infants of different sex and race between singleton and products of multiple births did not show differences, therefore for the purpose of this study, all infants were grouped together. During the five-year period, total number of deliveries declined 13% in the rural areas and increased by 6% at the urban hospitals. Of the 1,160 VLBW infants born in the region, 54% delivered at Level III, 29% at the urban (four Level II, one Level I) and 17% at the 27 rural Level I hospitals. Throughout the years, the incidence of VLBW infants increased at Level III (2.7% to 3.2%), remained unchanged at Level II (1.1%) and declined at Level I (0.6% to 0.4%). Simultaneously, a four-fold increase in the number of rural county mothers delivering VLBW infants at the RPC was documented. The majority of these mothers were referred and/or transported by ambulance (93%), private vehicle (5%) or helicopter (2%) from Level I rural hospitals.

Of the 97,309 deliveries which occurred at the 27 Level I rural hospitals during the 1979-83 period, 45% took place in maternity services with less than 800 deliveries per year.

Neonatal Mortality

Neonatal mortality by location and level of hospital of birth is presented in Table I. Overall, neonatal mortality was significantly lower ($p < 0.001$) for those born at Level III (36%) than for those born either at the urban Level II (52%) or rural Level I (54%) hospitals. VLBW infants in the 500-750 gm birth weight group experienced the highest neonatal mortality when born at the urban hospitals (88%) and the lowest when born at the Level III center (68%). Infants in the 750-1,000 gm birth weight group showed the highest mortality (60%) when born at the rural hospitals and the lowest (43%) when delivered at the Level III center. Neonatal mortality for infants in the 1,001-1,250 gm birth weight category was similar for infants born at the Regional Perinatal Center (13%) and at the urban community hospitals (18%). VLBW infants in the same birth weight group born at the rural Level I hospitals experienced a neonatal mortality rate significantly higher (26%).

Neonatal mortality rates for the first day of life by birth weight, location and level of care of hospital of birth are presented in Table II. Twenty-two percent of those born at the Regional Center, 38% of those born at the urban and 51% of those delivered at the 27 rural maternity hospitals died during the first day of life. All of those differences were statistically significant ($p < 0.001$). To assess the magnitude of changes which may have occurred during the five years of the study, data for 1979-80 and 1982-83 were pooled together. Neonatal mortality for VLBW infants declined from 50% to 42% for the entire

Table I
Neonatal Mortality (%) by Level of Hospital of Birth (1979-83)

Level	Urban		Urban		Rural	
No. Hospitals	III		I & II		I	
Birth Wgt (gms)	I		I & 4		27	
	#	%	#	%	#	%
500-750	102	(68)*	117	(88)	94	(83)
751-1000	159	(43)**	130	(52)	120	(60)
1001-1250	188	(13)**	129	(18)	121	(26)
TOTAL	449	(36)*	376	(52)	335	(54)

*Level III vs. Level II and I ($p < 0.001$)

**Level III vs. Level I ($p < 0.01$)

Table II
Neonatal Mortality (%) During the 1st Day of Life (1979-83)

Location	Urban	Urban	Rural
Level	III (RPC)	I & II	I
# Hospital	I	I & 4	27
# VLBW Infants	449	376	335
Mortality (%)	22*	38	51

*Level III vs. Level II and I ($p < 0.001$)

region, a finding which was statistically significant ($p < 0.02$). The declines per level of hospital of birth were: 8% for Level III, 15% for Level II (urban) and 12% for Level I (rural). These place of birth specific changes were not statistically significant.

Discussion

The incidence of VLBW by hospital of birth and level of care observed here is similar to that reported for New York City,⁴ Illinois^{3,6} and Iowa.⁷

Grouping together singleton and products of multiple births did not distort the results of this study since we, like others,⁴ have found neonatal mortality rates to be similar. The discrepancy between the number of black VLBW infants born at the urban and rural level depends more on the ethnic distribution of the general population than on a selective access to the source of care.⁵ Furthermore, when corrected for birth weights, VLBW black infants in our region experienced similar neonatal mortality to whites. Gortmaker et al.,⁵ who reported racial differences in survival, were unable to include data from Ohio for those under 1,000 gm birth weights.

The shift in place of birth for the VLBW infants reported here indicates that an active maternal referral program has developed. This is the result of statewide outreach efforts which included multiple visitation to the region by the authors as well as other faculty of the Regional Perinatal Center. A full-time educational coordinator for each perinatal region has been supported by the Ohio Department of Health throughout these

years. This position provided liaison, identification of regional educational needs and coordination of services. Unlike the experiences in other states^{4,7} and in another part of Ohio,⁵ in our region a large percent of VLBW infants are born at the Level III Center. This change in place of delivery, consistent with regionalization of perinatal care, has been associated with decreases in neonatal mortality.⁸

Like others,^{3,9} we believe that with proper screening, patients in premature labor and/or with prematurely ruptured membranes could be safely transported. During the five years of this study, maternal transports from the region were almost exclusively directed to the Level III center rather than to the Level II hospitals. During the study period, none of the Level II centers had a full-time perinatologist while the regional center had four full-time specialists in maternal-fetal medicine, two neonatologists, and pediatric, obstetric and anesthesia house staff.

It has been postulated that the size of maternity units may affect the outcome of pregnancy. The implication is that small delivery services seldom have the facilities or manpower needed to cope with the occasional delivery of high-risk infants. What seems to be true for populations of newborns in general does not seem to apply in our region to a highly selected risk group like the VLBW infant. Similar observations have been reported for Iowa, where 37% of all deliveries in the state occurred at community hospitals with fewer than 500 deliveries/year and no differences in outcome in relation to hospital size were noted.⁷

Improved survival for VLBW infants born at the Level III center is similar to that reported earlier by us² and later by others.^{3-5,7} The lower neonatal mortality recorded for VLBW infants born at Level III centers is more remarkable considering that maternal referrals of patients in premature labor is often complicated by other obstetrical high-risk factors.³

Neither Paneth et al⁴ nor Gortmaker et al⁵ observed differences in neonatal mortality for VLBW infants in the 500-750 gm group by place of birth. On the other hand, the results of the present as well as those of an earlier study² showed statistically significant differences in favor of those born at the Level III center. Recently, Hack et al,¹⁰ reporting on the outcome of infants with birth weights <750 gms, concluded that survival could be improved if early aggressive management including intubation and ventilatory support are implemented. Since we have endorsed similar posture for many years, it is likely that the different survival rate reported here is due to more aggressive medical management. The smaller difference in survival of VLBW infants in the 1,000-1,250 gm group if born at Level I and II (urban) contrasts sharply with the higher mortality for those born at Level I.

Neonatal mortality rates for the first-day of life have been attributed to the level of technology and skills available at the hospital of birth.^{4,5} Higher first day mortality at Level I and II maternity hospitals underscores critical differences in intrapartum and newborn care with the Level III institution and reiterates the importance of place of birth on survival of the VLBW infant.

In spite of the above, the establishment of a maternal referral program and the overall improvement in survival highlights the success of regionalization of care for at least this selected group of high-risk patients.

REFERENCES

1. Toward Improving the Outcome of Pregnancy, White Plains, NY, The National Foundation — March of Dimes, 1976.
2. Cordero L, Backes C and Zuspan FP: Very low-birth weight infant I. Influence of place of birth on survival. *Am J Obstet Gynecol* 143(5):533, 1982.
3. Miller T, Densberger M and Krogman J: Maternal transport and the perinatal denominator. *Am J Obstet Gynecol* 147(1):19, 1983.
4. Paneth N, Kiely J, Phil M, et al: Newborn intensive care and neonatal mortality in low-birth weight infants. *N Engl J Med* 307(3):149, 1982.
5. Gortmaker S, Sobol A, Clark C, et al: The survival of very low-birth weight infants by level of hospital of birth: A population study of perinatal systems in four states. *Am J Obstet Gynecol* 152(2):517, 1985.
6. Raju T, Winegar A, Miller S, et al: Place of birth for very low-birth weight VLBW (1500 grams) infants: Does it matter? *Ped Res* 18(4):231A, 1984.
7. Hein HA: The status and future of small maternity services in Iowa. *JAMA* 255(14):1899, 1986.
8. McCormick MC, Shapiro S and Starfield BH: The regionalization of perinatal services. Summary of the evaluation of a national demonstration program. *JAMA* 253(6):799, 1985.
9. Knox GE and Schnitker KA: In-utero transport. *Clin Obstet Gynecol* 27(1):11, 1984.
10. Hack M and Fanaroff AA: Changes in the delivery room care of the extremely small infant (<750 g). Effects on morbidity outcome (Special Report) *N Engl J Med* 314(10):660, 1986.

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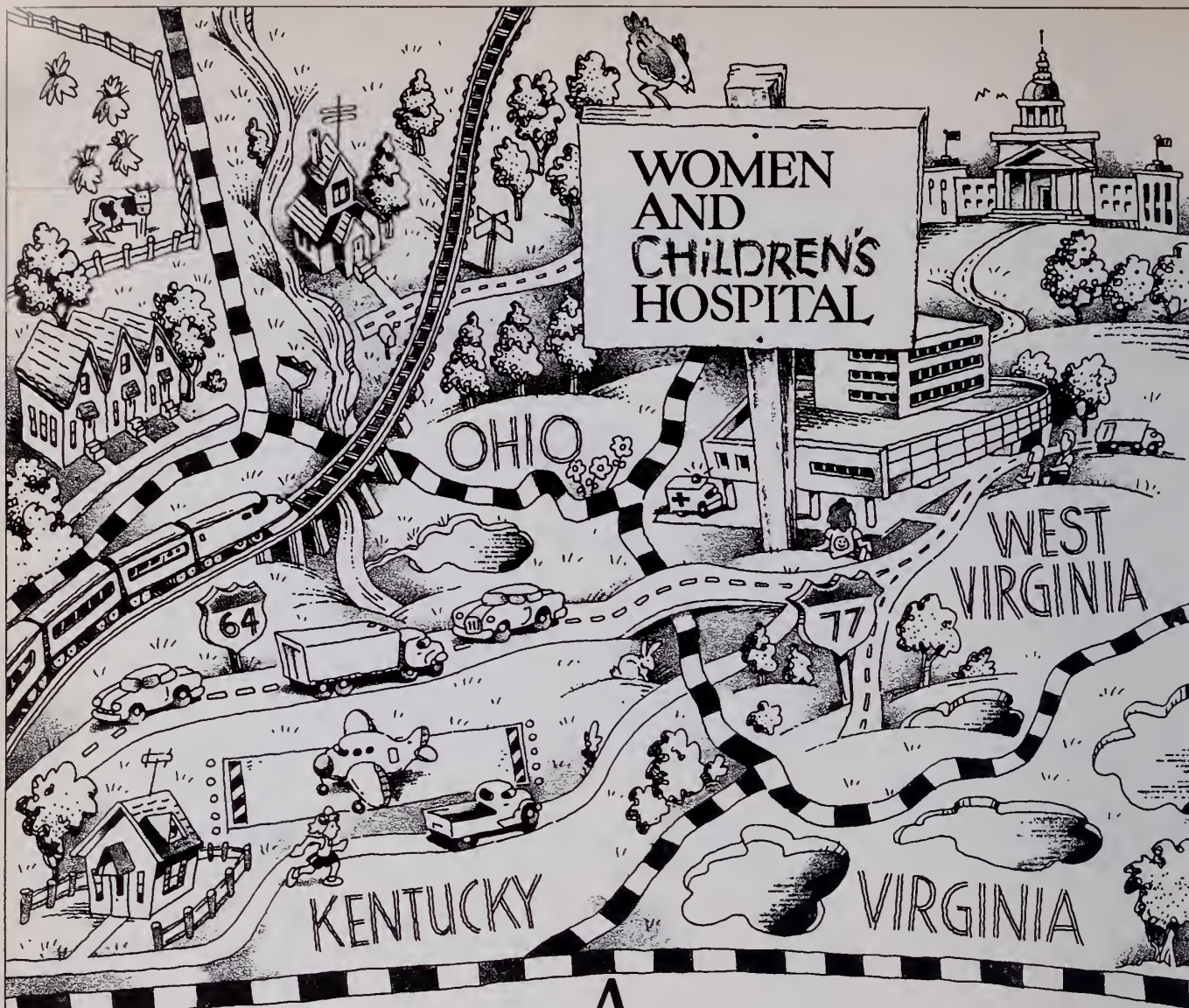
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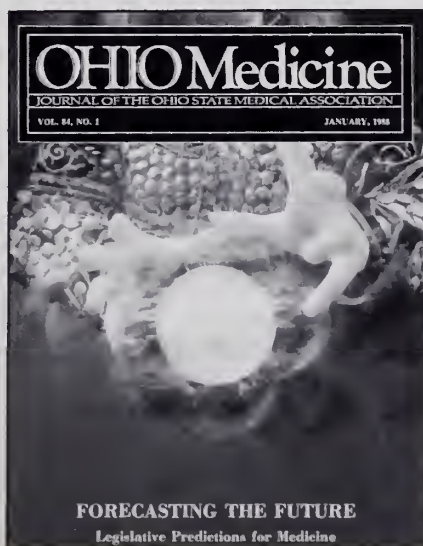
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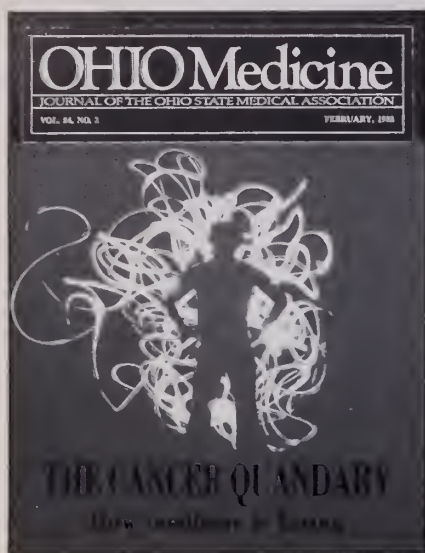
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OHIO Medicine
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CINCINNATI NOVEMBER 11-13

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nitroglycerin

2.5 mg/24 hr, 5 mg/24 hr, 10 mg/24 hr, 15 mg/24 hr

**Helps angina
patients get more
out of life**

*Significantly reduces both the
frequency of anginal attacks and the
need for sublingual nitroglycerin¹*

*Preferred by patients over 7 to 1 for
convenience compared to their
previous long-acting oral nitrate; only
12% had no preference (n = 4,300)²*

All transdermal nitroglycerin products are being marketed pending
final evaluation of effectiveness by the FDA. Please consult
brief summary of Prescribing Information on the following page.

C I B A

1988, CIBA 629-5558-A

BRIEF SUMMARY (FOR FULL PRESCRIBING
INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE

This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS

Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS

In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS

Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued. Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS

Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued. Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION

Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS

A patient leaflet is supplied with the systems.

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C87-23 (Rev 7/87)

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Summit, New Jersey 07901

C I B A

References:

1. Martines C. Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H. Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium. San Francisco, October 1987.

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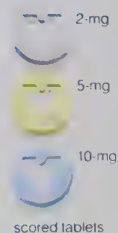


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